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# A La Croisée des Chemins

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DEPUIS quelques années déjà, la revue officielle des infirmières canadiennes publie chaque mois un article d'intérêt général en français, ainsi que les principales activités de l'Association pouvant intéresser celles d'entre nous qui ne connaissent pas la langue anglaise.

Aujourd'hui, la rédaction nous fait l'honneur de l'éditorial, ce qui nous permet de venir causer quelque peu d'une question qui intéresse non seulement les dirigeantes de la profession, mais aussi les jeunes infirmières et les étudiantes à qui seront confiées, dans un avenir prochain, les destinées de notre Association. Cette question est celle que se pose le voyageur à une croisée de chemins: "Quelle route dois-je prendre pour atteindre mon but?"

L'éducation en nursing est à cette croisée des chemins et il s'agit pour nous de considérer quelle route il nous faut prendre pour atteindre le but. Notre profession est jeune, et au fur et à mesure que la médecine progresse sa tâche devient de plus en plus lourde et difficile.

Le nursing occupe aujourd'hui une place des plus importantes dans les organisations sociales. Ses ressources ont été évaluées, ses programmes d'études modifiés, les possibilités de son développement exploitées, reste à savoir quelle catégorie d'infirmières sera requise pour les temps à venir? Quel genre de programme devrons-nous adopter? Quels moyens emploierons-nous pour maintenir les standards? Autant de questions qui relèvent non seulement de notre profession, mais aussi de tout citoyen intéressé au bien de son pays.

Nous en sommes à la croisée des chemins vous ai-je dit. Dans certains milieux l'on préconise l'école centrale où tous les cours scientifiques se donneront dans une université ou un collège, puis l'enseignement pratique dans divers centres reconnus pour l'expérience nécessaire à la formation exigée. Ailleurs l'on considère que les cours théoriques doivent être répartis durant les deux premières années avec une expérience clinique minimum, pour ensuite terminer par les stages de travail pratique quand tout l'enseignement théorique sera terminé. Certaines écoles ont adopté le système alterné de cours théoriques et pratiques (block system), les élèves étant à l'école pour trois mois consécutifs, puis au travail pratique pour les mois

suivants. Et là où les vieilles méthodes ont été quelque peu respectées, il y a les cours théoriques en même temps que l'expérience pratique pour la durée du cours de trois ans.

"Lequel de ces chemins conduira plus sûrement au but?"

Ceci dépend de ce que demain la société nous demandera. Cette profession est la nôtre c'est vrai. C'est nous qui devrons répondre de ses responsabilités. Nous nous devons aussi de protéger le public que nous servons, toutefois est-ce que le public réalise que s'il est intéressé à être soigné, il doit s'intéresser à l'éducation et à la formation de celle dont il aura besoin en temps opportun.

Le travail de l'infirmière est difficile, compliqué ai-je écrit au début de cet article aussi faut-il que l'aspirante aux études de la profession possède une instruction primaire assez étendue. Soigner un malade comme individu, ceci demande une étude de "l'Homme" dans toute sa complexité et ce n'est pas dans trois ans que tout ceci peut se faire. Il faut que l'élève nous arrive bien préparée et que nous n'ayons pas à lui faire compléter son cours d'études primaires avant de la mettre à l'étude de la profession. Encourageons donc nos jeunes filles à poursuivre leurs études primaires de façon à ce qu'elles puissent répondre à la noble vocation d'infirmière le jour où le bon Dieu les y appellera.

Puis essayons de prévoir quels devoirs nous attendent, alors nous pourrons choisir la route qui nous conduira au but que nous envisageons — celui d'aider nos concitoyens à garder leur santé ou à la recouvrer s'ils l'ont perdue.

Vous me ferez sans doute remarquer une grande vérité, c'est que le nursing a fait des progrès gigantesques durant les dernières années. C'est très vrai et c'est justement pourquoi son champ d'action a pris des proportions gigantesques. Les cours spéciaux organisés par nos universités pour les dirigeantes d'écoles et de nos services d'hygiène sociale ont fait un bien immense. Le développement des associations provinciales et nationale a favorisé l'expansion de la profession d'une façon merveilleuse.

Les hôpitaux ont pourvu leurs écoles d'un ameublement moderne et confortable. Des champs d'expérience clinique ont été ouverts dans tous les domaines de la médecine et de ses spécialités. Mais, il nous reste encore à étudier et à perfectionner. N'oublions pas que nous vivons le siècle de la bombe "atomique." Que tout se modifie d'une façon collossale en quelques mois quand ce n'est pas en quelques semaines.

Vivons notre temps! Apportons à notre siècle toute notre coopération au bien général et ceci aidera à notre profession qui est le champ d'action confié à notre sollicitude.

SR. VALÉRIE DE LA SAGESSE,
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*Présidente*
*L'Association des Infirmières de la Province de Québec*

## At the Crossroads

Sister Valérie de la Sagesse, in her guest editorial, discusses the problems that face not only the leaders but every member of the nursing profession. Like the traveller at the crossroads, nursing education faces a variety of choices in the immediate future. Which road will lead most surely to the ultimate goals of all nursing service—keeping people well—providing expert care when they are ill?

Present-day trends point toward a variety of developments—the central school, a concentration of theory in the first two years of student work, the block system. Many schools adhere strictly to the program that has been the pattern for many years. Which road should we take?

Although the actual decisions regarding nursing problems logically should be made by the nursing profession, there are many

places where the public can and must have a voice. As Sister notes, the public must be made to realize that if they expect to be cared for when the need arises, they must interest themselves in the education and training of those who will provide the care. They can assist young women to secure a full preliminary education so that when they enter a school of nursing it is not necessary to complete their background knowledge. An understanding of people is especially important in developing the students' appreciation of the patient as an individual, not just a "case."

The universities have a part to play in providing new opportunities for potential leaders. Our provincial and national associations have given impetus to professional growth. We are living in the "atomic age" when the tempo of life has quickened immeasurably. Every nurse must give her cooperation in building the future structure of our professional life. Only thus will the right decisions be made and the profession be strengthened.

# Timing in Children's Surgery

ALFRED W. FARMER, M.D., M.B.E.

*Average reading time — 16 min. 6 sec.*

THIS ARTICLE is designed to acquaint you with current thought as to optimum time when certain common conditions of children might be expected to benefit most from operative procedures. This involves in some cases discussion of the aims of such surgery. Where difference of opinion concerning therapy exists among members of the staff of the Hospital for Sick Children, Toronto, or where their opinion is at variance with that of other schools, mention will be made of it. For purpose of presentation, variations from the normal—i.e., disease—may be divided into certain large groups. Thus, consideration of congenital anomalies will be followed by a few words concerning common traumatic and infective lesions and miscellaneous states.

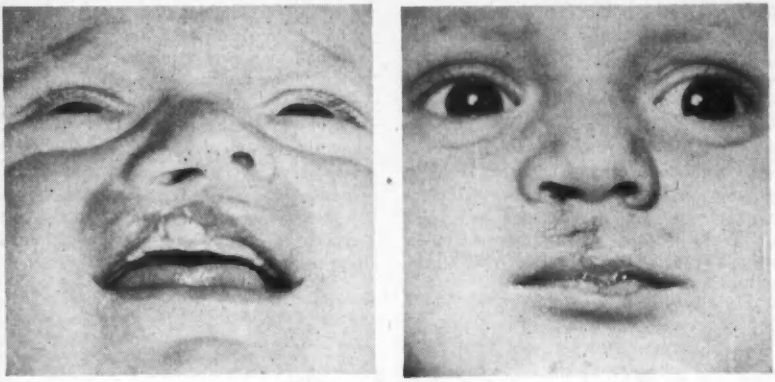
By congenital anomalies is meant marked deviations from the normal which exist at birth. Some of these are obviously inherited and others may be due to prenatal influences on the developing embryo. Certain illnesses and depressed nutritional states of the pregnant mother might affect the growth of the embryo, particularly in its early development. These anomalies are very numerous and a number of them will be dealt with rapidly and without much detail. Notation of congenital abnormalities is not placed on birth certificates so that no accurate information as to their incidence is available. They are more common than ordinarily suspected. Some method of recording their nature and incidence would give valuable information and should be established.

Dr. Farmer is associated with the Hospital for Sick Children, Toronto.

## ANOMALIES OF THE HEAD

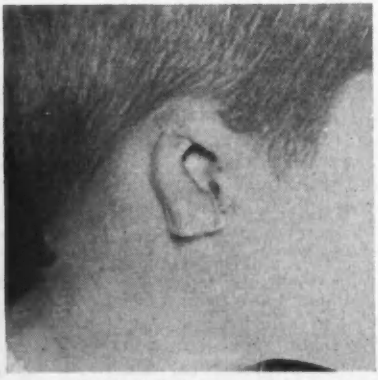
Cleft lip is more frequent on the left than the right and much more common in the male (70%). Faulty or interrupted fusion of the elements, of which this part of the face is formed, is the cause. There is a hereditary tendency. Immediate operation is not imperative. In some centres the lip repair is performed within the first two days of life. In other centres, and this applies to the thought at the Hospital for Sick Children, delaying the surgery for about two months lessens the technical difficulties. The lip is larger and thicker. The feeding problems have been solved and possibly the infant is better able to endure the trauma of operation.

Many anomalies, such as cleft lip, present deformities of adjacent



*Before and after repair*

parts. Thus the single complete and the double cleft also have defects of the nose. It is questionable whether severe nasal displacements should be corrected at the same time as the lip operation is performed. My opinion is that manipulations of the nose involving incisions of cartilage and wide separation of skin from underlying fixed tissues is not advisable at this time of life (two to three months) and that the late correction of the residual associated nasal deformities is better at thirteen to sixteen years of age. Deformities of the jaw and teeth associated with the cleft lip and palate are the responsibility of the dental profession. An orthodontist can work wonders with the irregularities of the teeth and malocclusion. The ability to afford such treatment and the small number of orthodontists available may limit this endeavor. It is, however, well worthwhile. Have the dentist see these children early.



*Partial deficiency of ear*

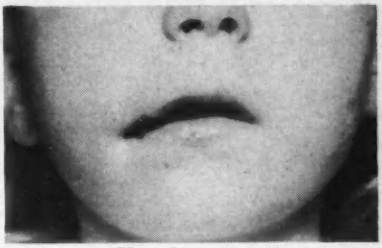
The timing of cleft palate repair is more variable than for cleft lip. At the Hospital for Sick Children, the repair is performed at about one and a half to two years of age. The spring and summer months are preferable due to the incidence of nasal infection in the late autumn and winter. Lately, however, with the use of drugs such as penicillin, the operating season has been extended. There are surgical centres where the palate closure is performed shortly after birth and others where the parents are persuaded to leave the closure until six or seven years of age. Many arguments are used to defend whatever timing is employed.

The aims of cleft palate surgery are to create anatomic relationships which will give certain expectation of normal speech, to close the defect for the purposes of oral and nasal hygiene, and to improve respiration and deglutition. Whether the conditions which will ensure normal speech are known is debatable. It is contended, however, that a soft palate which will separate the nasal from the oral part of the pharynx is essential. This condition may be obtained by operations on the pharynx to bring it forward or narrow it, as well as on the palate to increase its length. The forepart of the palate may be de-

liberately left open in order to obtain as much tissue as possible for a long soft palate. This anterior opening can be closed later by a dental plate or obturator. Thus the operative techniques are variable and well upheld by those who champion them. This is because the results are still far from perfect as far as speech is concerned. Faulty speech habits may be formed before a perfect repair. The use of speech training is believed to be of great importance. It should be commenced early in life.

Deformities of the ears are not uncommon. They vary from anomalies in size and shape and position to partial or total deficiencies. The defects in size, shape, and position can usually be well corrected. Ears which stand out markedly are an example. They are called variously by such names as "bat ears," "lop ears," or "monkey ears." The correction is performed at about five years of age, just preceding the commencement of school. A later date will do quite as well however. The reconstruction of an ear, if one is partially or totally absent, is difficult. In fact, it is still classed by many as the most difficult task in reconstructive surgery. It is only in recent years that the results have justified the operation. Even this latter statement is open to question. Some results can certainly be classed as fair but none as excellent. It is wise to show the parents requesting such reconstructions what has and can be done before accepting their children as patients. Those operations are also performed at about five years of age.

There are rare anomalies which are associated with underdevelopment of the face bones, including the jaws. It is possible to improve the appearance of such patients by adding bone, cartilage, or soft tissue. This may be performed at any time but preferably late in childhood. A very large or very small mouth may be present. Such an anomaly is corrected early in the first year of life if it interferes with the taking of food. With a poorly-developed lower jaw, the tongue may have little support. It

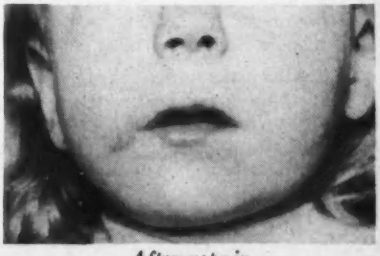


*Very large mouth*

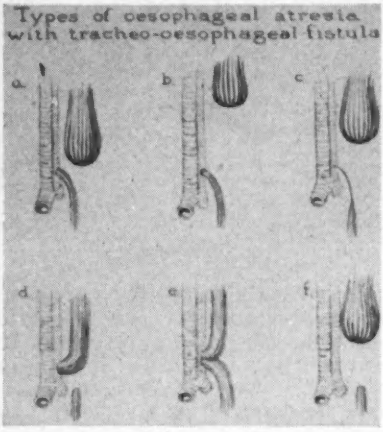
falls downward and backward and causes obstruction to breathing. This is particularly so if such infants lie on their backs or are not held up to nurse. In many, dyspnea and cyanosis are noted at birth. There is an operative technique which fixes the tongue in a forward position and relieves these symptoms. This should be performed within the first few days of life as soon as the diagnosis is made.

### Thoracic Anomalies

Branchial cysts or fistulae and thyroglossal duct cysts are ordinarily dealt with when diagnosed. There is usually no urgency about the surgical treatment so that a time suitable to all parties concerned can be chosen. Tracheo-esophageal fistulae, however, must be regarded as urgent. These are connections between the esophagus and the trachea present at birth. The sooner they are diagnosed the better. The nurse directs the attention of the physician to the respiratory difficulty which occurs when the child attempts to take food. Until recently all of these patients have died. Now it is possible to separate the esophagus from the trachea and restore its continuity by operating through the chest. The



*After repair*




sooner these patients arrive at a hospital where such surgery can be performed, the greater their chance of survival.

The great advances in vascular and thoracic surgery in comparatively recent times have brought aid to a group of children known as "blue babies." Recently on questioning the pediatrician who carefully examines these cases at the Hospital for Sick Children, concerning how soon he wished to see them, he answered that he would like to investigate this particular type of congenital anomaly as soon as it was noticed. From the surgical point of view, some surgeons state that they would like the patients to have reached at least five years of age before operation. This is because the operative work is easier when the anatomical parts, which it is necessary to handle, are larger.

Babies born with defects in the diaphragm, so that the contents of the abdomen are in the chest, should be operated upon immediately after the diagnosis, if there is respiratory or gastro-intestinal distress.

### Abdominal Anomalies

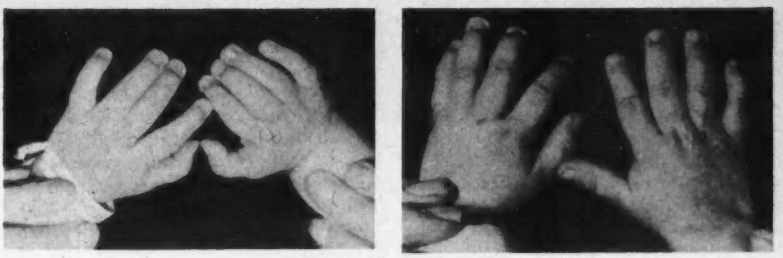
Some babies are born with defects in the anterior abdominal wall at the region of the umbilicus. A thin membrane (which may be ruptured) covers the viscera. Some of these cases should be operated upon immediately. It is impossible to save many as they have not enough space in the abdomen for replacement of large viscera such as the liver. However, in favorable cases the results are gratifying.

The new-born child, with an imperforate anus, is no longer operated upon immediately. A delay of a day or even more is sometimes helpful in determining the position for the rectum which fills with gas and can be visualized by x-ray examination.

There are many more congenital anomalies within the abdomen which require immediate operation. One example is a complete atresia of the bowel at some point, and another is the absence of the proper channel from the liver to the bowel for the passage of bile. Such conditions are recognized very soon after birth and should be operated upon almost immediately.

### Anomalies of the Limbs

There are many congenital anomalies of the limbs about which the question arises as to when the operative work should commence. With congenital clubfeet, a common anomaly, the manipulations may be started immediately by the nurses in attendance. The splinting may be commenced at two to three weeks of age. For webbed toes or overlapping toes there is no special care indicated. In the case of webbed fingers the separation of these is usually performed late in the first year of life but may be delayed. Accessory fingers and toes may be amputated at any time. The parents may have a feeling of embarrassment about such conditions and urge their correction. Double thumbs may present somewhat of a problem. As a rule neither of those present is a normal digit. The choice of which to amputate is difficult. A better single thumb might be obtained by amalgamating the double thumbs later in life. With congenital constricting bands with elephantiasis, a rare anomaly, the work may be commenced at a month or so of age when the general care of the child has been organized. In cases without elephantiasis there is no hurry and the operations, which are chiefly for cos-



*Before and after repair*

metic purposes, may be commenced at any age.

A rather common condition for which timing in therapy is all important is congenital dislocation of the hip. The earlier such cases are recognized the better. If there were any reason to remotely suspect such a lesion a roentgenogram should be taken. Good results depend almost entirely on early therapy and become progressively worse with the passage of time.

### Spinal Anomalies

An anomaly of the vertebral column, with a defect of the bony protective covering of the spinal cord and nerve roots, is very common. This may be associated with a hernia of the meninges, with a mass protruding from the midline of the back. The covering may be of tissue paper thickness or it may be of normal skin. In many cases there are associated conditions, such as motor and sensory paralysis of the lower limbs and no control of urination or defecation. Such cases are often rushed to the hospital at birth. On discussing this matter with our neurosurgeon, he suggested that only those babies with meningoceles with a very thin covering, and who had little or no sensory or motor disturbance, should be regarded as emergencies. They are regarded as urgent because with rupture of the thin membranes there is danger of meningitis. Those with good skin coverage may be dealt with as elective procedures later in life. Those with extensive paralysis might better remain at home as fill a bed in a hospital, as there is nothing of a constructive nature to be advised.

### Collections of Fluid

There are conditions other than congenital anomalies concerning which it is important to have some knowledge about timing. Blood vessel tumors or hemangiomata can be very troublesome if they are allowed to grow to such a size that their destruction leads to severe deformities. This is particularly so in the case of cavernous hemangiomata on the face. Many cases are noticed as defects of pinpoint size shortly after birth. Within a few months they may involve completely the upper or lower lip, or the side of the face and neck. Such rapidly growing tumors should be treated while small, when the problem is comparatively easily solved. At a later date no matter what therapy is used some deformity results. This is one of the conditions where timing in therapy is often at fault.

There is another type of case for which much can be done if the babies are seen early. Any baby who has a fit or fits and who has a tight fontanelle should be investigated as to the possibility of a subdural collection of blood or serous fluid. Such cases are being recognized much more often nowadays than previously. The continued and increasing pressure of these subdural collections of fluid causes irreparable brain damage unless relieved early. In many cases it is the nurses' observation of such babies which leads to the physician instigating proper care.

### Traumatic Lesions

There are certain traumatic lesions where the time element in treatment is very important. That most commonly seen in children is burns. All

severe burns (over 5-7 per cent) of the body surface should be taken to hospital immediately. Patients with over 15-20 per cent of the surface injured are in danger of losing their lives unless adequate general treatment with intravenous solutions is commenced immediately. This general therapy is more important in such cases than the local application to the burn surface. At a later stage, also, the timing in treatment is important and often wrong. If the entire depth of the skin has been lost an ulcer with a granulating surface results. If this is large, it should be grafted. Such grafting is commenced within three weeks of the date of the accident. Neglected cases have been admitted months and even years later when the work is more difficult and the end results are less gratifying.

Another common childhood condition, which requires early skilled observation and treatment, is a wringer injury. This is an exceedingly common injury due to children playing about with the home laundry apparatus. Squeezing the forearm and the arm between the rollers of a home wringer may not cause a break in the skin but, if the pressure has been great enough, the skin and subcutaneous fat will be separated from the underlying fascia and from its blood supply. Slow necrosis of large areas of tissue may result. This can often be prevented if suitable treatment is instituted early.

### Conclusion

Much more space might be used to mention other specific lesions. Enough examples have been given to demonstrate that immediate action is essential for the best result in some cases, while in others, despite the wish of parents to get operative work completed, there is definite reason for delaying therapy. Many conditions are best dealt with before the commencement of school due to the teasing the child may get from his school companions. Others may await further growth of the individual to avoid the necessity for repetition of operative work and to avoid damage to growth centres in bones. This applies particularly to the orthopedic treatment of many lesions, notably deformities and disabilities following poliomyelitis. Operations which are performed to equalize leg length during the growth period are prime examples of the need for accurate timing in surgery. The subject of scoliosis has not been mentioned. Here also the treatment must be timed accurately to obtain the best result.

Graduate nurses, who are such an important part of the medical profession and who, during training, have been intimately associated with serious hospital cases, and who have seen the magnification of troubles in patients brought for care at unsuitable times, can help immeasurably by virtue of their extensive and close contact with the population at large.

## Pernicious Anemia

The mortality from pernicious anemia has been drastically reduced since the use of liver in the treatment of the disease was introduced in 1926. Each age group in both sexes has benefitted very materially from the improvement in mortality. Deaths from pernicious anemia at ages under 45 are now extremely rare. Even at 65 to 74 years the reduction in mortality since the introduction of liver therapy has been well over 50 per cent in each sex. The marked decrease in the death rate at these later ages is particularly noteworthy, inasmuch as liver therapy does not cure pernicious anemia but only keeps it under control, with the result that the number of people with the disease at the older ages has been increasing. But so effective has the treatment proved to be, that the majority of patients who adhere to a prescribed regimen have been able to carry on their usual pursuits and usually live long enough to succumb to another cause. Prior to the era of liver therapy, the average duration of life after diagnosis of pernicious anemia was 2½ years.

# Routine Care of Decubitus Ulcer in Paraplegia

R. M. McLean

*Average reading time — 6 min. 24 sec.*

THE MOST prominent susceptible areas for the development of decubitus ulcers are the ischial, sacral and trochanteric areas, the knees and heels. When a paraplegic patient is admitted to the special Centre an appraisal is first made by the physician with particular attention to decubitus ulcers. Only in rare cases are such ulcers immediately amenable to plastic surgery; in most instances they require preliminary medical treatment. The physician orders routine cultures and daily dressings.

Pre-operative as well as post-operative daily dressings demand a strict aseptic surgical technique. Large open ulcers and all post-operative cases are dressed in the dressing-room. The patient is transferred to this room from the ward in his bed and dressings changed while in bed. For smaller ulcers the dressing cart is taken into the ward and dressings changed with meticulous care.

In the dressing-room a number of items should be available at all times. These include several dressing sets consisting of a tray with dressings and swabs, tongue depressors, applicators, small kidney basin, sterile towel, probe and director, artery, tissue and thumb forceps, and one pair of straight surgical scissors. These are placed separately in a heavy calico envelope-shaped bag, with a long flap to fold over, and are sterilized by autoclaving. A large trocar and syringe are kept sterile in the dressing-room for the early aspiration of hematoma.

A trained orderly to assist in the dressing-room is essential. He must be familiar with the correct technique in handling sterile dressing-room supplies and with posturing of patients on abdomen or sides as indicated for dressings, intrathecal alcohol blocks, lumbar punctures, and manometric tests.

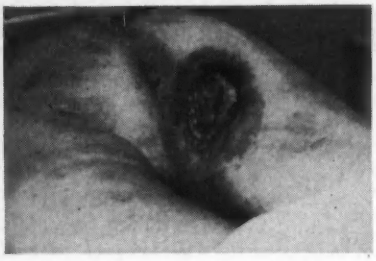
Miss McLean is in charge of the Dressing-Room, Paraplegic Centre, Ste. Anne de Bellevue Hospital, Quebec.

## Pre-Operative Care

The posture of the patient is of utmost importance. No pressure must be applied to open parts. In dealing with sacral or ischial decubitus ulcers the patient is placed on his abdomen with several pillows under the head—sufficient for comfort. Four pillows under the chest assure freedom of elbows, pillows under thighs and shins provide space under the knees and under the iliac crests sufficient to permit proper urinary drainage, tubing, etc. The feet are braced against a foot-board to prevent foot-drop.

For the supine position the pillows are arranged in the same manner. This will keep all the pressure points free and, in addition, allows dressing of supra-pubic wounds or ulcers on the iliac crests, shins, and heels.

The skin is cleaned with ether and alcohol and the ulcer with hydrogen peroxide. Dead tissues are removed with scissors and 20 per cent mercurochrome is applied. After cleaning the wound, ultra-violet therapy is administered daily by the physiotherapist and the Stitt Pencil is used in presence of a sinus. Then the surrounding area is painted with a thick coating of tincture benzoin compound (Friar's Balsam). This protects the skin and acts as an additional adherent for elastoplast. This material is secured by fastening at one end and firmly drawing it across the dressings, guarding against creases in the skin which could cause further decubitus ulcers. If the wound is deep or a sinus is present "Tulle Gras" packing is



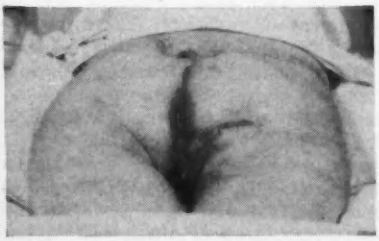
*Ischial pressure sore requiring treatment prior to plastic closure.*

used, but all greasy substance must be removed from the outer rim of the ulcer with ether in order to prevent sloughing.

The outlined treatment of decubitus ulcers is a lengthy procedure. When finally healed it was frequently found that the scarred tissue was adherent to bone. With the impaired circulation application of any pressure to the weakened area immediately caused the reopening of the healed ulcer. Therefore, plastic surgery was attempted and healthy tissue brought over the affected area, thus hastening the rehabilitation process and enabling a greater turnover of patients. Cautery with silver nitrate applicators is frequently indicated over granulations which cease to progress or grow too rapidly at the edges of decubitus ulcers. Silver nitrate is also used to prevent invagination of the epidermis into the crater and its adhesion on underlying bony surfaces. Curettage is often indicated and done by the physician.

### Post-Operative Care

The dressings are changed daily to keep the suture line and surrounding area dry, to prevent the tissue from becoming soft, and to maintain a firm suture line. One can check for hematoma under the plastic flap by gentle pressure around the operative site, noting any seepage between sutures or the presence of old blood in surrounding areas. The skin is then cleansed very lightly and carefully to keep the suture intact and every suture is closely inspected.



*Following plastic closure of decubitus ulcer.*

In the presence of infection, which may occur at suture points, the minute area is cauterized with pin-point silver nitrate applications. After the fifth post-operative day infra-red treatment is given daily by the physiotherapists and in fifteen to twenty days every alternate suture is usually removed. After three weeks all the sutures are out, but dressings are still applied for a further few days. The area is then exposed if there has been no infection or complication. However, infra-red treatments are continued for approximately six weeks post-operatively and patients allowed heliotherapy in summer. Daily gentle massage is applied by the physiotherapists. This stimulates blood circulation and prevents adhesion to the underlying bone.

During the sixth post-operative week the patients are allowed to sit on the edge of the bed for approximately fifteen minutes for three days prior to sitting up in the wheel-chair for short periods. The incision is then inspected for any redness or blisters which may have been caused by friction. Should the area continue to remain in good condition the patient is allowed up for graduating periods of time. After the seventh post-operative week the patient is usually engaged in full rehabilitation. In some cases where surgery has been performed on the ischial region it has been noted that a small padded dressing to the area for a week to ten days has been effective in preventing recurrent decubitus ulcers while getting into the wheel-chair.

### Conclusion

1. Decubitus ulcers in cases of

paraplegia can be prevented by proper posturing.

2. Pre- and post-operative dressings, when plastic surgery has been done, require close supervision and can assist in a greater turnover of patients in the Paraplegic Centre.

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# Guidance for Student Nurses

M. AUGUSTA MARTIN, M.A.

*Average reading time — 14 min. 6 sec.*

GUIDANCE IMPLIES a philosophy, which stated simply, is faith in individual worth, acceptance of, and belief in the individual. The purpose of a guidance program is to foster better adjustment of the individual nurse with maximum growth personally, professionally, and socially. This alone would justify a program but, in addition, secondary values are yielded, such as improvement of nursing care, smoother running administration, a more economic training.

Personnel administration is "the direction and co-ordination of the human relations of any organization with a view to getting the maximum production with a minimum of effort and friction, and with proper regard for the genuine well-being of the worker." Within the general field of personnel administration lies the guidance program.

Guidance first came to the fore in industry, primarily as a means of increasing production. Ordway Tead has stated the principle succinctly: "A dynamic influence urging the organization towards clearer formulation of aims, and adequate publicizing of them; toward fuller unity of purpose and *conscious* morale." Industry was more or less cornered by organized labor. Since a good employer keeps one jump ahead, anticipating needs and avoiding trouble, guidance programs were instituted.

Guidance in education came to the fore, first to deal with problem chil-

*Fawdry, Calgary*

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dren, especially those who were psychiatric cases. With a change in the philosophy of education from the "fact-finding" to a "process within an individual" to "the business of earning a living" to the "art of living" it is now realized that every child needs guidance. It has a preventive aspect. Educational programs must be rebuilt around thought, feeling, emotion, interests, and asthetic tastes as related to social drives.

Guidance in nursing, by that specific title, may be rather new. As we study it, we find it closely resembles something we have known all along, though we may have failed to do as much about it as we should. In 1901, in Buffalo, on the occasion of the first International Congress of Nurses, the late Mrs. Bedford Fenwick said:

> A nurse cannot live by learning alone . . . the heart must be cultivated with as much assiduity as the understanding . . . nurses must take their part in the civil and social movements of our time, realize the obligations of citizenship, and appreciate at their true value national and international events. They must live *with* others, not altogether *for* them.

In an early issue of *The Canadian Nurse*, Miss Isabel Stewart, formerly director of nursing education at Teachers College, had made a plea for an improved system of nursing education. She outlined many principles we now label *guidance principles*. In her book, "The Educational Program of the School of Nursing," Miss Stewart wrote:

> The primary function of a school is education. When a hospital or other agency operates a school for the purpose of getting work done in an economical way, the function of that school is primarily economic, not educational . . . it is not a real school unless education is its main responsibility . . . The chief purpose of education is to help people to live better and serve better. It is not a case of education *or* service, but education *for* service . . . Education is a process of full healthy growth. Education is also defined in terms of adjustment to life—helping individuals to use all their powers and capabilities in meeting problems of life and in adjusting to changing conditions. Training is a necessary part of education . . . but with too much emphasis on skills and too little on thinking, the growth of the individual will be limited, and also his power of adjusting to new demands . . . In nursing we need more than a machine-like impersonal efficiency. Education is a lifelong process. The aim of a school of nursing is to select well-qualified applicants and to help them to realize as fully as possible their potentialities as individuals and as nurses, to the end that they may give their best service to society and at the same time achieve the greatest happiness and satisfaction in their own lives.

Perhaps, like industry, we shall be cornered if we do not take immediate steps. Many schools of nursing have been forced to stop and consider, due to the shortage of applicants, the increase in withdrawals, and the increased need for service to the public. Four very important facts must be faced:

> First, sooner or later the school of nursing must be independent of the hospital. Second, the director of the school must take the lead in the guidance program. Third, we must conduct our schools according to democratic principles. We cannot expect to have a "thinking and a doing" staff or student body if "thinking and doing" are not encouraged. We cannot blame the young graduate who shows no interest in the profession if we shove and push her through training, urging blind obedience and conformity to tradition. We must foster a training for democracy. Fourth, we must learn to work together on all policies —administrative staff, school of nursing staff, any guidance personnel, nursing service staff, and a representative from the student body.

We are able to apply our knowledge of psychosomatic medicine to our care of patients. Do we treat our young student nurses with the same consideration and understanding? It is perhaps their first time away from home, everything is new, they are afraid and lonesome. They have possibly just left high school. Residential life, study problems, relations

with doctors, supervisors, other students, and limited social activities must be faced. What do we know of them? Have they adjusted well? Are their behavior patterns sound? Are they maladjusted? Do they have problems? They are only human and they do have problems. I recall one conservative school of nursing where there were no money worries, a lovely nurses' home, an elaborate "guidance" program—but no mention was ever made of counselling. We were told students in that school just didn't seem to need counselling, didn't seem to have problems. Can we believe that? Several hundred student nurses who do not experience any problems? Why did the staff not know? To whom did the students go for help when troubled?

Studies of withdrawals from schools prove the students frequently do not feel they can go and discuss things with the staff because of fear of sarcasm, ridicule, disinterest, or failure of staff members to keep confidences. They go instead to friends, classmates, their favorite doctor, the clergy, their family. A story, not at all an isolated case, tells of a pregnant student who reported her condition to the office, and was in no uncertain terms "called down" and ordered home, "in disgrace" and "immediately." Some time later the parents informed the school they had not heard from their daughter for some weeks. Questioning of her former classmates revealed that they and their parents were financing that girl's stay in the city while she received medical and psychiatric help. The students were near to the girl in her hour of need—the staff was not.

Counselling is at the heart of the guidance program. It implies a relationship between two people—one of whom has the problem, the other of whom is presumably experienced to deal with problems. The principles are: allegiance to the counselled, fostering of self-respect by the counsellor, neutrality and open-mindedness on part of counsellor. The sequence in helping the student is to identify and understand the problem, focus and integrate all the facts, seek solutions and jointly make decisions and plans. All these steps must be taken. A good counsellor never superimposes her own ideas.

Counselling cannot proceed in a vacuum but is supported by:

1. *Cumulative records:* These should contain pertinent data, understood by the staff, and available to the proper staff members. In some schools students have access to their own records.

2. *Informational service:* We must know possible solutions and answers, keep sources of information, catalogues, etc., available, and know where to go for further help.

3. *Referral resources:* We should know and use all available agencies—e.g., religious, psychiatric. Counsellors may be available in the community whose assistance can be secured.

4. *Trained staff:* We may start with a core and enlarge through our in-service program, or we may, when replacement is necessary, add staff members experienced in counselling.

5. *Record of counselling:* All counselling should be recorded, however brief the account may be. Small cards slipped into the folder are usually sufficient. Name, date, topic discussed, anecdotal account of interview, interpretation by the counsellor, and her signature can be jotted down in two minutes.

6. *Continued contact:* No problem is an isolated one; we must see the student repeatedly to get at the real problem.

The counselling program centres around the services already existing in the school:

1. *Recruitment, selection, admission:* The profession as a whole—each hospital, each nurse—is responsible for recruitment and must increase the understanding by the public, 'teen-age girls in particular, of the opportunities in nursing. Are our private duty, general duty, staff nurses, and supervisors a good advertisement to the public?

In accordance with the standards of the school, and to meet the needs of the individual student, selection takes place, based on objective evidence regarding the students' abilities and assets. It should be possible, with a reasonable degree of accuracy, to

predict her success as a nurse. Rejected applicants would benefit from counselling.

2. *Orientation—a continuous process:* The objective of orientation is to help the student to have an appreciation of the course she is entering; to realize the importance of her own health and be willing to accept responsibility for it; to realize the necessity of full participation in all phases of life in the school for adequate adjustment and growth—personally, socially, and professionally; to formulate her own program for successful completion.

3. *Counselling:* The aim may be to first relieve a situation which is causing the immediate difficulty, but the ultimate aim is to give the counsellee capacity to cope independently with future situations as they arise. In *personal counselling*, we must see each girl as a growing, developing personality, working out an integrated pattern of life. Personal counselling assists the girl in self-directive ability. *Religious counselling* implies a permissive attitude on the part of the counsellor in helping the girl to solve her problem in the light of her own accepted interpretation of life. *Financial aid* may be necessary in order that a student of ability, but with meagre personal finances, may be able to pursue her desired profession. Information regarding scholarships and loans should be available during recruitment, admission, and during the period of education for nursing.

4. *Discipline* must be an experience of educational value. It should stress self-direction and student initiative rather than blind obedience. It should be adjusted to the mental, social, and emotional level of the student. Self-discipline implies the opportunity of choosing the right action when the wrong one is also available. Only when free to choose does the student exercise her intelligence and initiative. If we assume the student will do right, accept her as a mature lady, we may expect adult behavior.

5. *Educational guidance* is a process concerned with bringing about, between an individual pupil with her distinctive characteristics on the one hand and differing opportunities and requirements on the other, a favorable setting for the individual's growth—intellectually and educationally. Satisfactory adjustment is a need of all students. *Vocational guidance through counselling* has an opportunity to assist students in clarifying their objectives in such a way that they may see and understand their socio-economic value, and in mapping programs which will prepare them for economic self-sufficiency as soon as desired after leaving the institution.

6. *Student-faculty participation in government:* This implies a democratic administrative body and teaching faculty, who believe the student capable of self-direction and self-discipline. It implies an alert, responsive body of students willing to assume increasing responsibility for the welfare and happiness of others. The school of nursing, as a small unit in a democratic society, should prepare the nurse for future performance in a democratic world.

7. *The social program:* The school of nursing is a laboratory for social living. The program should assist the student in proper relationships with her fellows and in social adjustment in a society of well-established patterns and traditions. It should be initiated by the students themselves with support and co-operation from faculty. It permits of unobtrusive group guidance by a counsellor. An individual must be able to perform in the group—one cannot live alone. Life in a school of nursing could be made into one of the most controlled experiments for we have the raw material, reacting agents, activators, medium, etc., and the whole twenty-four hours of the student's day to work with.

8. The *health program* should be educational, a learning experience, to promote positive physical and mental health.

9. The *placement program*, following graduation, is a means of bringing about employer-employee contacts easily and efficiently, and at the same time offering guidance through counselling. A true and complete picture of the employee is transmitted to the employer. The follow-up program is based on a continuing spirit of co-operation and interest in our nurses; their success or failure reflects perhaps on them but as well on the placement office and certainly on their school.

10. *Records* provide a means of securing information that will provide a basis for understanding the individual student in order to guide her as intelligently and sympathetically as possible. Research and evaluation stimulate growth and progress of the total problem and provide a means of determining to what degree it meets or fails to meet its objectives. They assist those in charge of the program to discover what they have to work with, what they lack, trends and changing emphasis, and the need of change in policy.

You may well wonder where all this leaves us. Maybe we cannot have a school of nursing separate from the hospital. The director may not be sympathetic towards efforts at guidance. Maybe a democratic atmosphere does not prevail in all our institutions. However, we can always respect individual worth, show sympathy and understanding, help as many students as possible to remain well adjusted, happy, young girls. Whenever possible we should try to head off maladjustment and never contribute to it by our own inadequacies.

In closing may I mention a visit to a school of nursing in a negro hospital. Added to all the problems that besiege us, they have the color problem. The educational director, a most inspiring person, was explaining to us the challenge she felt, in spite of the overwhelming odds. Her illustration told of the argumentative young son, aged five, who had been particularly trying. "Son, you jes' argue all the time," his mother complained. "Well Ma," the child replied, "how can I learn, if there jes' aren't no'un to talk up against?"

And so that, too, may be our challenge. And we may find we have a lot of "talking up against" to do.


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# Professional Guidance

RUTH FRANCIS

*Average reading time — 7 min. 12 sec.*

BECAUSE OF CHANGING CONDITIONS and the complexity of modern life and the need for assisting each individual through her own efforts "to increase in wisdom and stature and in favor with God and man," guidance is a necessity in every school program. A nursing school is no exception. Here the student should be guided in solving professional and vocational, health and social, and educational problems in order that she may develop her whole personality to the fullest extent and that she may be able to adjust well to situations and contribute as much as she can to the profession and society.

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As time goes by there is an increasing demand for the person with professional qualifications. The future status of nursing and the schools of nursing themselves depends in a large measure upon the ability of the directors of nursing, their faculties, and the nursing personnel to develop in every student the potentialities which make for a well-balanced person and an efficient nurse to the end that she may find happiness and satisfaction in her professional and personal life. It is necessary that each school evolve its own plans for guidance to meet the needs of the students.

In order to help the young student nurse make adjustments, achieve the accomplishments, acquire the qualities of the professional nurse, and make her contribution to the pro-

fession after graduation, guidance is planned in terms of the student's needs. Assuming that high schools have vocational guidance programs and that the principals are supplied with information regarding the necessary entrance qualifications, the characteristics of a person able to adjust well to nursing, the standards of schools of nursing, etc., the school of nursing guidance program begins with the careful selection of students and continues to function throughout the course.

As a good selective program helps the school to assist in maintaining sound ethical and professional standards, it is important that selections be made carefully for the benefit of the student as well as the school and the whole profession of nursing. The applicant should first be made to realize that, though the work is not easy and material returns are not great, her work will be of unfailing interest. It calls for the exercise of many different qualities and abilities. Then, if she signifies her intention to become a nurse, certain information concerning her intellectual capacity, her behavior, personal history, potential abilities, and her physical and mental health is obtained and appraised. After such a study the director is in a position to advise the student as to whether she should enter nursing or seek some other field of work. If the student is accepted the information obtained at this time is kept and used in planning guidance during her training.

From the time the student enters the school until she leaves it she is constantly meeting unfamiliar situations and requirements which make prompt and adequate adjustments necessary. These involve the growth and personal integration of the student herself, and her relations with the people with whom she comes in contact. She needs guidance and assistance all along the way in making adjustments and developing the desirable qualities.

Just as soon as possible, it is necessary to establish a clear understanding in the mind of the student as to what nursing is and what fundamental characteristics are essential for a good nurse. It is also necessary to have her feel that the faculty and the nursing service staff are interested in her success, expect her to succeed, and are always willing to help her. She should be made to feel that she can go to any member of the staff for help and advice in any problem that may arise, but that she herself must accept full responsibility for making her own record a successful one. She should be imbued with the professional spirit and taught the importance of maintaining professional standards in her own work, and of helping to strengthen and advance such standards in the group as a whole.

Since the essential foundation of professional standards and conduct is integrity of character, and since good ethical principles play a major part in character development, a course in professional adjustments must put its main emphasis on the ethical aspects of professional problems. These classes should be arranged early in the junior period to aid the student in adapting herself to her new environment and to give her an appreciation of her responsibility to the patients, the school of nursing, the hospital, and her coworkers. Concurrently, individual guidance should permeate the whole program. In this way the student can be guided to a better understanding of herself and the qualifications for nursing.

Toward the latter part of the training period, when the student approaches graduation, there is need again for concentrated attention on professional relationships and problems. The director or her assistant should be responsible for this program but representatives from other professional groups might be asked to give talks and lead discussions. At this time, the student should be given an understanding and appreciation of the *professional responsibilities of the graduate nurse* to society, herself, and the professional group. She should become acquainted with some

of the personal and professional problems which confront graduate nurses and she should acquire some facility in analyzing and judging situations which she is likely to meet in professional life, and learn some of the principles and methods that are likely to be helpful in such situations. She should learn of the opportunities open to professional nurses and the qualifications demanded in the various branches of nursing. She should be fully aware of the professional organizations and their activities, their nature and purposes. She should learn to use intelligently the resources of current literature and other means which help in continued growth and in successful adjustment to the professional field.

Guidance concerning future employment should be given greater emphasis. Some students know what they want. Others do not. Helping a student to select a first position is one of the most important phases of a guidance program. At present, a new graduate is often offered a position for which she is not really fitted. The wise young graduate selects a position where she will be under guidance. Frequently, the nurse most in need of guidance accepts a position where she will not have sufficient supervision. It is a well-known fact that executives frequently hire without asking for credentials and then criticize the school, from which the nurse has come, for her failure to make good. It is a serious problem and one in which the employer needs to be educated.

The new graduate in selecting a field should make a thorough investigation of the one in which she is most interested to see if it offers the opportunities she thinks it does. It should include a study of: (1) the status, development, and importance of the occupation; (2) the work done in it; (3) the income of those employed in it; (4) the preparation required for it; (5) the advantages and disadvantages. Following this study she should make a self-analysis to see if she is fitted for this particular work from the standpoint of preparation, personality, health, and home responsibilities. In analyzing her personality she should consider especially self-sufficiency and self-confidence. When these two tasks are completed she should seek guidance of a counsellor before making a final decision. The counsellor, making use of the cumulative records, should help the student to evaluate herself and guide her towards choosing a field for which she is particularly fitted, and in which she can find happiness and opportunities for further growth.

Having studied the field of nursing and made a choice, the nurse requires some guidance on finding, securing, and leaving positions. Not every nurse knows how to go about looking for a position. She should know that she can find them through schools of nursing, advertisements in professional periodicals, friends, and placement bureaus. She should also be made to realize the value and importance of making as many contacts as possible in seeking a position; of creating favorable impressions through letters of application and personal interviews; of writing letters of resignation, giving the required notice; and of leaving with a good feeling toward all concerned. The common courtesies that make for goodwill and success cannot be overstressed at this time when the student is about to enter the professional world.

The success of the professional guidance program can be judged by the changes that take place in the student during the three years. If she acquires a fund of knowledge, useful to her in everyday experience, a critical and reflective mind, skills permitting her to administer good nursing care, the ability to organize work logically and co-operate with others, develops new attitudes, appreciations, and values, and is a good nurse in the estimation of her fellow-workers and the general public, then the staff may feel that the objectives of their program have been achieved.

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A doctor gets less work from six men than from one woman.—*Spanish proverb.*

# Gardening as a Hobby

E. Aileen Rogers

*Average reading time — 2 min. 48 sec.*

Four or five years ago a neighbor and I were talking over the back fence about the scarcity of food and how nice it would be to live in the country where you could grow it. That was the beginning of a healthful and profitable hobby. We found one did not have to live in the country to grow things.

Our first garden was in a vacant lot on a busy street in a large city which was a bad place, as everyone passing stopped to talk to us and we got little done. (In those days it was a strange thing to see people gardening in a vacant lot!) However, the city plowed for us and we cleared the land of sods and rocks and raised a fair crop of vegetables. There were four of us, each with our own plots. The next year other people got ahead of us and took our space, so we had to look for another spot. We found one in a better location but further away from home. The city again plowed for us and we began to battle the weeds. Weeds are our biggest problem as the place is surrounded by big obnoxious plants which seed every year and spread to our lots. This time there were nine gardeners—three of the original group and six new ones.

Our lots are about 15 by 70 feet in size. I do all my own work, digging and all, except when I can work Tom Sawyer's trick and entice one of my friends to partake of a little healthful exercise.

Primarily, my garden is to grow vegetables, but my love of flowers and strange plants is too great and I grow anything new that comes out. I have a strip, one full length of the garden and about three feet in width, which is for flowers and herbs. I grow herbs for salads and for perfume. They make a lovely gift after I have painted a fancy jar for each.

One of the neighbors has a canning machine and a large pressure cooker, so we can can enough beets, beans, and tomatoes to do us all winter as well as make tomato juice. The tin and gas bring the cost to five cents a can plus a fraction of a cent for the seeds. (My seeds, flowers and all, cost me $8.00 last year.) We have all we want fresh as well as canned and plenty for our friends. Also we never buy an onion. They dry nicely. Squash, turnips, and pumpkins keep well too. One year we had our last hubbard squash in April the following year.

The bugs are our worst enemy, after the weeds. The bugs sit on the fence jeering at us until their favorite vegetable or flower comes up, then they pounce. They even seem to be able to escape the poison we put on them. Of course we have two-legged pests too! The birds eat the seed in the spring and the people steal our produce in the summer when things are ripe. It is amazing how some people can steal out of a garden when they would be horrified at the idea of robbing a store! I usually grow a row of carrots at the bottom of the garden hoping the children will take these and leave the rest alone, but it doesn't work with adults.

Anyone can have a garden. A vacant lot and a couple of evenings a week are all that is necessary. The seed catalogues and packages give directions for growing (they don't always grow as they are supposed to, though), how to kill the pests, etc. The weeds are easy to recognize. If it is exceptionally healthy-looking it is a weed. No seed planted by hand ever seems to be as sturdy as a weed.

As well as a garden I have a full-time position from nine to five, as nurse in charge of Student Health Service at McGill University. We find gardening lots of fun to say nothing of the good exercise we get. I feel my health has improved 50 per cent since I took up gardening.

*Institutional Nursing*

# In-Service Education

N. Osiowy

*Average reading time — 12 min. 48 sec.*

*Without vision, thy people perish.*

There will always be a Tomorrow and if Tomorrow is to be worth living in, it will have to have its roots in Today and Yesterday. The traditions that have sustained us in the past will sustain us in the future. The experiences that we have had in the past ought to provide guides for our actions in the future.

So spoke a famous director of education in an address given at the University of Minnesota some years ago. Those words should be our guide in formulating our policies in nursing education today. Many revolutionary changes were instituted during the war years to meet the critical situations which then arose. Harassed supervisors and head nurses strove to give nursing service and had little time to improve their own experience or professional education. Many tasks were, through necessity, given to inexperienced workers. Because of inadequate staff, nurses had to trespass upon the physician's territory and non-professional personnel trespassed upon nurses' territory. Now the time has come to revamp our programs. All will agree that many strands must be picked up again. One such thread is the resurrection of in-service education.

## What is Education?

Basic knowledge, gained through professional education and broad experience, is an essential qualification. But equally important is the continuation of that education if we are to grow. Professional education may be compared to any evolutionary process. Nothing and, therefore, no one stands still. Either we progress or we retrogress. Our objectives in nursing truly defined, therefore, should foster further professional education.

"Conscious education aims to improve life." Since no experience leaves us unchanged, consciously or unconsciously, we must begin by analyzing ourselves. How are we reacting in this post-war world? Are we giving way to hysteria or are we controlling our emotions in spite of the lack of security in the world in which we live? The answer is in ourselves. Yes—we can control our emotions, if we know ourselves. We must realize our abilities and limitations. In view of these findings we must set ourselves a valued but attainable goal. Thus, we will reach an inner security. Once that security is attained we can accomplish more with ourselves and with others.

*And all life is vain*
*Save where there is urge,*
*And all urge is lost*
*Save where there is work,*
*And all work is meaningless*
*Save where there is love.*

Having attained this inner security, the next step is to attempt to improve our professional education. This entails more than one would suppose at first glance. When studying any subject we must first become familiar with its meaning. Let us then define education. Education implies deliberate direction and training in fulfilling human needs and values which are socially acceptable. *All* learning starts

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Mrs. Osiowy has deserted the nursing field for housewifely duties in Lemberg, Sask.

with a need to "discover" the correct or satisfying response to stimuli. Because we are subject to stimuli all our lives, education should be a lifelong process. Here we are concerned with nursing education. How shall we educate? And whom? And in what directions?

There are many ways to promote professional education. Some of the more common include: Travel; active participation in professional associations; subscribing to and carefully perusing professional literature; experience in the field; self-study or formal study such as the attendance at night school or summer school; organized programs of in-service education.

Whom shall we educate? In this instance, we are concerned with the graduate nurses employed in hospitals. What material shall we present for educational purposes? Briefly, the program must be one to suit the needs and meet the interests of the persons concerned. Now, let us see how an organized program might be introduced and operated in a situation where the following people would be employed: general duty nurses; private duty nurses; head nurses; supervisors; teaching staff.

### Starting the Program

The person responsible for instituting this program is the director of education or the superintendent of nurses who, along with her other responsibilities, absorbs many of the duties of the director of education. It would be preferable that she organize a committee for in-service education. Acting on this committee should be a representative from each of the groups mentioned. Suitable arrangements should be to have each of the sub-groups meet separately for their study period. Actual problems of hospital management should be discussed at some other staff conference. The representatives of the group concerned meet with the director of education to discuss the program on the agenda prior to each meeting. Each member of the group should be informed on the topic to be presented.

A definite time, included in the duty day, should be set aside at regular intervals for the study period. The material should be adapted to suit the needs and interests of the individuals concerned. The program should be planned carefully and cooperatively by each group. This will help to stimulate interest in the projects undertaken. Library facilities, including those available in the community, should be easily accessible to the staff since ward libraries cannot contain all the material a staff member might wish to consult.

All in-service education actually begins with an orientation to the position. This starts by supplying a prospective employee with a job analysis. This outline will help to give her an over-all picture of the responsibilities and opportunities attached to the position. It has been proved in industry that satisfactory introduction and adequate tasks of instruction save time, money, and workers. Why should this be less true in hospitals? We may presuppose a certain amount of useful knowledge gained from previous experiences. But the individual concerned has never before held this particular position. Therefore, it behooves us to provide adequate orientation.

Orientation is begun during the initial interview. The superintendent of nurses, after making the policies of the hospital clear to the nurse, will ask her to report for duty on a certain day. At that time she will introduce the floor duty nurse to the supervisor of the department where she will be working. An invitation to attend staff conferences and study groups should also be issued at this time. The supervisor will, in turn, acquaint the floor duty nurse with:

> The ward layout; the ward personnel; all routines and procedures of the ward, particularly if the nurse is a graduate from another hospital; problems pertinent to this particular department.

### General Duty Nurses

At the first meeting of the study group, a tentative outline of the

material to be discussed would be drawn up with all the members participating. This program would be planned to meet the needs and interests of the floor duty nurses. In order to promote interest sufficient motivation must be supplied. Therefore, it is particularly important that *all* individuals attend and participate in the discussion. A suggested study program for this sub-group might be:

Films of current interest followed by discussion.

Demonstration of new procedures and routines—e.g., change in perineal care.

Some of the newer drugs and treatments —e.g., streptomycin and its administration.

A speaker from a professional group other than nursing—e.g., attorney, coroner, physician, speaking on material pertinent to the hospital, nursing and legal ethics.

A revision of the job analysis for general duty nurses.

Appraisal of student performance.

Meetings should be of approximately thirty to forty minutes' duration. They should always be followed by a brief snack. As Dr. Athol Gordon said, "The attendance will grow as you feed the personnel."

### Private Duty Nurses

This sub-group provides its own peculiar problems. Here, the turnover is usually great so that only a simple in-service program may be carried on. It will consist chiefly of the orientation and then supervision (a form of administration and also a form of teaching) in the department in which the private duty nurse works. Systems of introducing the private duty nurse to an institution vary but perhaps the most favorable method is to have the nurse report to the school of nursing office when she presents herself for duty at the hospital. She could then be turned over to a student or secretary who would conduct her to the main points of interest, e.g.: dressing-room, diet kitchen, central supply room, dispensary, dining-room. The private duty nurse should then report to the supervisor on the ward where she will work to be introduced to the patient or to the other nurse on the case. A supervisor is just as responsible for the nursing care received by a patient with a private duty nurse as she is for a patient who has no special nurse. This, if realized by all private duty nurses, makes for better service for the patient. Therefore, close co-operation between the supervisor and private duty nurse is absolutely essential.

One means of promoting interest in this sub-group is to have a bulletin board, with clippings of interest posted on it, in clear view in the department. This board should be kept up to date with the clippings changed frequently by the members of the department. Another incentive toward further education would be to have a card file available, containing information on commonly used and new drugs. This file should be kept in each chart room. It might be built up by the study groups of the staff nurses, or might be a project assigned in the classroom to the student nurses.

Any organized plan for in-service education, by means of meetings at specific intervals, is impossible with this group since seldom will the same nurses be present on successive days. However, with such a program as outlined, the private duty nurses will be supplied with a means to increase their fund of knowledge.

### Head Nurses

Here again, orientation is the beginning of the educational program. The most logical person to do this is the supervisor or the person whose vacancy is to be filled. Naturally, the superintendent of nurses introduces the head nurse to her department head and issues an invitation to her to attend study sessions. At the first meeting, the head nurses should draw up a program for a definite period of time — say three months. This should be done co-operatively if the enterprise is to be successful. The following are suggestions for study by head nurses:

The place a bulletin board has on a ward.

Making out time schedules and delegating work to the staff.

Evaluating nursing care.

How to conduct a clinic.

Films of current interest.

Discussions of new drugs and treatments.

Demonstration of new procedures and routines or revision of old procedures.

Means of improving food service.

Outlining of duties for the head nurse or revising them.

Revision of evaluation records for student nurses.

Hearing a speaker on a topic of current interest—e.g., health centres.

Guided discussion should be the keynote. The leader should be chosen from the group.

### Supervisors

The supervisors should know any new procedures and routines, the new drugs and treatments, be familiar with films of current interest and be up to date on all changes in the policies of the hospital but their program must go further than that. It must include the objectives of administration and supervision of education and nursing care. A suggested outline, planned in conjunction with members, might be:

Ward teaching program.

Revision of techniques and procedures.

Rating scales for head nurses.

Achievement tests.

List of duties for maids, orderlies, and ward helpers or revision of the lists if such lists are already in existence.

No group meeting should be of such a length that it becomes a burden to anyone to have to attend it. The meeting should be brought to a close with the serving of some simple refreshments.

### Teaching Staff

These people must be aware of all the changes taking place in medical science and practice. They might have an organized program of in-service education along these lines:

A study of entrance tests suitable for potential student nurses.

Study and revision of the school of nursing rules.

A revision of course outlines for student nurses.

Attendance at any meetings in the hospital or community should, if possible, be part of the instructor's duty day. Naturally there will be occasions when this cannot be arranged.

Several of the meetings listed for the various sub-groups might be combined — e.g., films of current interest, outside speakers, etc. It is preferable, however, not to do this too frequently for discussions tend to be more stilted if the general duty nurses, head nurses, and supervisors are all at one meeting. To promote more freedom of discussion separate meetings are for the most part advisable.

Naturally, not all people will receive the same benefit from an in-service program. If we achieve nothing more than greater satisfaction in the day's work and increased interest in their profession on the part of the staff in general, we will have accomplished a great deal. This may appear to be a very ambitious program but we should be able to implement a workable plan in our nursing institutions. We will make many mistakes, but working together we should succeed.

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# Counselling in Industry

VERNA HUFFMAN

*Average reading time — 10 min. 12 sec.*

COUNSELLING methods are something which each of us uses every day. How good these methods are varies with the individual, and with her moods. All counselling is a combination of natural attributes and acquired skills. During our training as nurses, we were so busy learning how to do, that there was insufficient time to learn how to be vocal in the interpretation of our goals, and the way in which they might be attained. Most of us have had to develop our own techniques by trial and error, but today there is available to us a wealth of material with which to enrich our counselling competency. Here it will be possible, only, to refresh our memories on some of the generally accepted fundamental principles, so let us start with an elementary illustration — the A.B.C. of a successful industrial health program.

The degree of participation in the health service is the criterion of its success. Hence, complete employee participation is our objective and this we shall represent by C — *complete participation.*

But participation is never any greater, nor any less, than the level of employee understanding — so it follows that C will equal B, if B = *basic employee understanding.*

Basic understanding is in direct ratio to, and dependent on, the adequacy of interpretation — so B = A if A represents *adequate interpretation.*

Following the logic of our geometry if A = B, and B = C, then A = C, and we find the degree of participation equal to the adequacy of interpretation.

Counselling is the art, technique, or skill whereby one interprets and makes available her knowledge and resources to individuals who want them. True counselling is designed to assist the employee in constructive consideration of what to do with his immediate problem, and to clarify basic issues involved, thereby preparing him to deal with his own future adjustments.

Interviewing is the means by which counselling takes place. The three fundamental techniques are listening, observing, and careful questioning. The successful interview must be in private, unhurried, and free from interruption. These things reassure the apprehensive employee and cut down his hesitancy to discuss his problem. The employee should be assured that all information is treated confidentially but only a high standard of personal integrity in this regard will be convincing. Since the success of the initial interview gauges the rapport and co-operation of all subsequent interviews, it is essential that it be a really effective one. If circumstances are not propitious, treat the emergency or problem at hand, and leave the interview until a mutually agreeable time. Then be ready for that appointment and do not keep the worker waiting. If delay is unavoidable be frank about it and either give him something he will enjoy reading or, if practicable, give him something to do for you.

The interview should be conducted on a friendly, direct basis, meeting the employee on his own level, talking neither up to, nor down to him. En-

Miss Huffman is a nursing counsellor with the Civil Service Health Division of the Department of National Health and Welfare, Ottawa.

courage the employee to tell his story in his own way. In questioning do not force the employee to say more than he wants to but try to get information essential to social investigation. If it is necessary to take notes in the presence of the employee, limit the notes to dates, figures, or objective facts which can be written in plain view. The permanent record, which will be made after the interview, should include a condensed summary of problems presented, issues faced, issues unsettled, positive steps taken, and referrals made.

In second and subsequent interviews it is wise to have the same nurse handle the case. It is less disturbing to the employee to talk with the same person and she has a clearer picture of the situation. During the first interview she will have learned much from the employee's manner, his method of approach, his verbal account, his gestures and movements. From these observations certain conclusions will have been reached but the nurse should be prepared to constantly review these conclusions in the face of new evidence. As the employee's confidence develops his real problem will be disclosed. Following the first interview the nurse should obtain any available information from interested agencies. With the added information some tentative plan of action can be drawn up. When the employee is finally prepared to discuss the real problem the nurse should guide his thinking into action.

It is essential that the nurse thoroughly understand the purpose, policy, and objectives of her health service, and that she be able to present its program interestingly and accurately. Such individual interpretations are the basis of a sound informed public opinion within the industry and the community. To be really effective, however, we must be aware not only of our own resources but also of those available in the community. We should be conversant with all regulations affecting employees, such as the personnel policies, conditions of work, etc. It is also necessary that we have a good working knowledge of the hospital and clinical facilities available; the social agencies and the type of service they give, their intake policies; the recreational resources and how the employee may become enrolled for a program which meets his needs. It will be very worthwhile for us to maintain a special file of the health, social, and recreational resources of the community and keep them readily available for the use of those whom we counsel.

The well-informed nurse has a rich store of information which she makes available to the employee who wants it, when he is in the mood to accept it, and leaves the decision of how he is going to apply it to his own discretion. The employee should be encouraged to assume his own responsibility and to expect from the nurse only intelligent understanding and constructive suggestion. If it is a personnel problem he should be assisted to analyze it, think out the various solutions, and then be encouraged to approach his appropriate supervisor or personnel officer. In some instances the nurse may facilitate these discussions between employee and employer through interpreting to the latter the needs of the former. Sometimes the nurse may find it expedient to refer the employee for vocational or psychological guidance, having ensured success by careful interpretation of that particular service.

In dealing with employee problems it is frequently valuable to know whether the individual or his family is known to a social agency, the type of problem presented there, and the service given. It is also important to know whether a social agency is willing and in a position to undertake or extend service to meet the present social problems of the employee and his family. If the nurse is in doubt as to the intake policy of any agency, or is unable to determine which agency gives a particular type of service, the local community chest or the municipal welfare offices can usually provide the information.

In calling an agency the nurse makes a confidential exchange of in-

formation but must be careful not to abuse the employee's confidences. She must never request the agency to initiate service unless the employee has requested this assistance. It is usually preferable for the individual to make application for service directly to the agency but the nurse may arrange a convenient appointment. However, where the employee is young and shy, emotionally disturbed or unduly apprehensive and requests the nurse to go along, she should comply graciously.

Once responsibility for social supervision of an employee is referred to and has been accepted by an agency, the nurse is responsible for this employee's health and welfare only within the place of work. Usually plans are worked out co-operatively between the nurse and the social worker to give the employee optimum service.

So far this has been a presentation of the theory of counselling methods and techniques. Now I should like to demonstrate the practical application of these techniques:

Sad Sal was eighteen years of age, the eldest in a family of five. She lived with her parents in a rural community — her work days began and ended with the long bus trip to the city. Daily bus trips may be interesting to some people, but not when you are so weary that you keep falling asleep and your head jerks forward as if it would break your neck. Well, our poor Sal's neck had had so many jerks from cat-napping that she sometimes felt it was on a swivel!

Sal wasn't a pretty girl but beauty experts tell us there is latent charm in each one of us. Sal's charm couldn't get through to the surface, buried under poorly washed skin, unkempt hair, loafers without stockings, and "hand-me-down" clothes! She was weary, she was worn and sad!

Sal's first visit to the health centre was early last fall — she came in in tears, complaining of fatigue and upset stomach. To question or attempt teaching when she was emotionally disturbed would have been wasted effort, so Sal was taken into the Quiet Room for a 20-minute rest period. The nurse telephoned her department to report that Sal would be in the health centre for a short time. The supervisor replied, in effect, "You can have her, we don't want her, she smells too much for us!" It was apparent that unless there was a quick clean-up job, Sal's days were numbered! The first step to be taken was to arrange another interview.

The following day Sal reported to the nurse in a better frame of mind. She stated that she was always too tired to get up early enough to have a good breakfast. Her lunch consisted of a sandwich and a coke; family dinner at night showed lack of planning and little knowledge of good nutrition. Because chronic fatigue seemed to be one of her chief difficulties, a medical examination was arranged. The medical findings were negative but the doctor felt that poor nutrition and poor health habits were largely responsible for her condition. He suggested that health teaching would be helpful, laying some emphasis on the need for recreation.

Sal was introduced to Mary MacFadyen's book "Beauty Plus." This stimulated her interest in good grooming, care of skin and hair, proper use of cosmetics and deodorants. She was interested, but felt the teaching was impractical in her case. They had no plumbing in their home and daily bathing was an impossibility. With four other children and two parents to be considered, Sal had difficulty in getting even a good daily wash. As for washing her underwear and stockings daily, she was too tired at night to be bothered.

The nurse then discussed the effect of good food and health habits on the general appearance of skin and hair. This roused Sal's interest in nutrition more than the fatigue from which she suffered chronically. Using "Canada's Food Rules" as a guide the nurse explained foods essential for daily body requirements. A copy of "Suggested Menus" was given to help Sal's mother in planning meals for the whole family. Since the other children were of school age, a copy of "The School Lunch" was given. These pamphlets, as well as other interesting literature, are available to all nurses in industry. The mother of this family is a busy woman and appreciated the interest shown in her brood — she sent word that any other literature on nutrition would be most welcome.

Sal had an aunt in the city. The nurse wondered if the aunt would be interested in helping with this project by providing the noonday meal. It would be less fatiguing and more pleasant than battling through the restaurants or aimlessly wandering the streets.

It was suggested, too, that some arrangement be made there for regular baths — perhaps even for washing out her underwear and stockings. Sal approached her aunt who agreed to co-operate — and so our young lady embarked on a "clean-up, beautify yourself" campaign! Sad Sal did not become Glamor Gal overnight, but she became a better nourished, better groomed individual, more readily accepted by her fellow-workers, and a more efficient employee.

The matter of budgeting on a very limited income presented many difficulties. To go into detail here would be superfluous but Sal was advised as to suitable clothing for office wear.

In this case from a simple upset stomach these various problems were raised and met: fatigue, inadequate nutrition, poor personal hygiene, and lack of recreation.

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## South African Military Nursing Services

Any Canadian nurse who served with the South African Military Nursing Services during World War II, and who is of the opinion that she has not yet received full settlement of:

(a) War pay and allowances,

(b) Pay and allowances in lieu of vacation leave due at date of discharge,

(c) Pay and allowances in lieu of 30 days non-recordable service leave (for service in the Middle East and Mediterranean theatres of operations),

(d) Cash and civilian clothing allowance of £30 (thirty pounds),

(e) War gratuity,

is requested to communicate immediately with the

*Chief Paymaster*
*Military Pay Headquarters*
*Union Defence Forces*
*"V" Buildings, Beatrix St.*
*Pretoria, Transvaal, Union of South Africa*

stating the following particulars:

(1) Regimental number

(2) Rank

(3) Surname (maiden name to be given if now married)

(4) Christian names

(5) Full address (this is important)

(6) Date of attestation

(7) Date of discharge

(8) Details which will assist to have the pay query investigated expeditiously.

## ℞ *Chuckles* P.R.N.

The coronary artery is located in the cornea.

Phimosis is inflammation of the breast.

The iris contains an organ called the pyloric sphincter.

The skin is where temperatures are neutralized.

The poorest type of nursing of the Dark Period of nursing is characterized by blue stockings.

A public health nurse asked a Grade II child from an exceptionally dirty home to name three domestic animals, to which he replied, "Cat, dog and louse."

*True or false:* "In Canada the mosquito transmits disease."

*Answer:* "This is true because they are known to transmit disease and they won't be any different just because they are in Canada."

Use a good deodorant to prevent offensiveness.

The skin is a sensation.

## Don't Tell your Troubles

The pattern of happiness is made up of many and varied small things. One of the most adaptable to the use of every man is pleasant and interesting conversation, a means of sharing the good in life with those about us. Never use it as a means of sharing your troubles with others.

— *Personews*

*Private Duty Nursing*

# Financing Private Duty Nursing Registries

BARBARA E. KEY

*Average reading time — 5 min. 12 sec.*

IT seems to be generally considered a problem to finance private duty nursing registries and keep them on a sound financial basis, with adequate office personnel, space, and equipment.

The cost of maintaining a registry office has increased, as has everything else, with the higher cost of living. Salaries are double and treble what they were a few years ago. Equipment, office supplies, rents, are double and more. This increase is not only a registry problem but affects every line of nursing as well as other walks of life.

The work involved in registry offices has increased, as it has in other lines of nursing endeavor, making added office staff, equipment, supplies, and space a necessity. The registry office cannot stand still any more than the nurse herself unless she wishes to be outdated and put on the shelf. It is necessary to move forward and keep up with the times so as not to be brushed aside.

Registry offices have become more than just places to call nurses and for nurses to receive calls. They are the business office of the private duty nurses, as well as a service to the community. They, of necessity, give a 24-hour service which requires at least three full-time and one part-time person, on an eight-hour day, with time off and vacation, which is the schedule of hours requested by private duty nurses and all other nursing groups. If we expect nurses to work in our offices, we must be prepared to pay them a salary which we ourselves would consider adequate to live on and not one comparable to ten years ago. There is also the problem of furnishings and supplies for the office, which should follow the same line of thinking. Our office staff must have the proper tools to work with or their efficiency is cramped, as well as their good nature. Therefore we must supply equipment which we ourselves would like to work with. Most offices require more space to carry on their work efficiently than they did a few years ago.

The staff of our registry office should, and do, carry on personnel work with the private duty nurses. They are the buffer between nurse and employer, often clearing up many misunderstandings on both sides. Counselling nurses and employers as to their shortcomings, commending

BARBARA KEY

Miss Key, who is national chairman of the Private Duty Nursing Committee, has been intimately associated with the management of the Community Nursing Registry, Hamilton, for many years.

their achievements, giving advice when needed or requested, and smoothing out many rough spots for the nurses is all part of the job. They enforce the standards and regulations of the registry, interpret the registry regulations to the public as well as the nurse, and in so doing clear up many wrong ideas before the nurse becomes involved. The registry also gives the nurse its support in any problems with which she needs help. If she is in the right they will assist in fighting her battles. Therefore it is up to us to find ways and means of maintaining our registry office as an efficient service to the nurse and the community.

Registries are an essential community service. The public, using the registry to meet their nursing needs, knows that nurses who are members of an organized private duty nursing registry are fully qualified registered or practical nurses, their credentials having been thoroughly investigated before being accepted as members of the registry. Doctors have every confidence in the efficiency of the registry and know the value of having a centre where they can call private duty nurses for their patients. They place their calls at the registry and realize the length of time and worry which they are saved. Hospital personnel have no time for lengthy telephoning in busy hours so call the registry and request nurses for the more critical cases. They know the registry will be able to locate nurses if there are nurses to be had. Lay people immediately call the registry when illness occurs in the family and ask them to send nurses. Then there are the calls from very excited parents, etc., when there is an emergency in the home asking where they can locate a doctor and what they can do until the doctor arrives. The nurse at the registry office is able to give assistance and reassurance to these people as well as sound advice to meet their needs. In these, and many other ways, the registry is a recognized service to the community. They also provide temporary general staff nurses to assist hospitals when short-staffed, relief for public health services, nurses for industrial nursing, doctors' offices, clinics, etc.

The registry, being the business office for private duty nurses, should be controlled by them. Therefore the board of directors is set up with the majority of members private duty nurses and a representative membership from other fields of nursing, physicians, and lay people. This representative board of directors ensures broader thinking and a more efficient service by the registry. Private duty nurses should be in key positions on the board, establish their own policies, with the combined thinking of the entire board. Policies which concern medical or hospital people in any way should be set up through a conference of private duty nurses meeting with those concerned and discussion of the problem to the satisfaction of all. If private duty nurses have control of their registries, set the hours of duty, rates, registry fees, engage their office staff, etc., they will find ways and means of supporting that registry. It is only human nature to take more interest in something you have established and are responsible for than something which has been set up for you and is controlled by others.

The financing of private duty nursing registries should be done on a sound business basis, with a workable budget drawn up each year and ways found to cover any deficit.

The following are some of the methods adopted to finance this project:

1. Private duty nurses should pay an adequate fee for registry service, which should be governed by the needs for financing the registry, according to the budget.

2. The auxiliary group of registrants—practical nurses, orderlies, housekeepers, etc.—should also pay an adequate fee, but since their rate of pay is less the fee should be less.

3. Telephone services offered by the registry to related groups might include:

(a) Victorian Order of Nurses calls taken after hours, Sundays, and holidays.

(b) Any other visiting nursing organization.

(c) Red Cross blood donors' clinic.

(d) Twenty-four hour telephone service for doctors when there is no answer to their phones.

(e) Any group which fits into the registry picture and requires a telephone service.

These services should be offered at a large enough fee per month to pay the registry for its extra work, and not started at such a low rate that it is difficult to increase the fee when the registry discovers the recompense is not sufficient.

4. The registry is an essential community service so should be entitled to a municipal grant and a grant from the local hospitals annually. The registry is as much a part of the community services as the V.O.N., the social agencies, etc.

5. There are other ways of raising money but they are not stable: (a) Bridge parties, with added attractions such as tea-cup reading, home-cooking sale, door prizes, etc.; (b) drawing for some valuable article with sale of tickets far enough in advance to give good results; (c) tag day; (d) a concert of the type which will attract the people in your community.

The rates for all services given by the registry should be estimated on a budget basis with each taking care of a portion of the upkeep of the registry.

## In the Good Old Days

(*The Canadian Nurse, April, 1909*)

"Today we had a baby brought into the Children's Ward, where I am now, who had swallowed a quarter. He is more expensive than any other of our babies who have come in with the same complaint — they are usually content with pennies! This is quite serious, however, as the quarter has lodged in his esophagus, and the consequences may be disastrous. So we are all watching him very closely. His mother, when I questioned her, burst into tears exclaiming, 'Oh, nurse! I feel that it is all my fault! He was playing with some pennies, so I took them away and gave him the quarter instead. I didn't dream that he could swallow that!'

"As this was visiting day, I found one of our babies that had been given money by his mother holding it tightly clasped in his little fist. I told her that she shouldn't give her children pennies to play with. She said very virtuously, 'I never give my children pennies, I always give them nickels . . . it is the copper that is bad!' "

* * *

Miss E. F. Holmes, in an address given to the Alumnae Association of Royal Victoria Hospital, Montreal, listed, in their order of importance, the following duties customarily expected of the private duty nurse permanently installed in a home:

"Private secretary, companion, lady's maid, nurse."

* * *

"I think if any scheme could by any possibility be devised by which our nurses could be taught the advantage to themselves of helping themselves to the knowledge which is lying all around them waiting to be picked up, we should all profit by it; instead of the attitude that all too often prevails of expecting somebody to stuff them with knowledge in the same way as they fatten chickens by chopping the food up and putting it down their throats."

* * *

"The world the nurse lives in is no larger than her interests. If her interests are limited to the routine work of the sick-room, she can never be expected to accomplish her best for the betterment of humanity in general."

* * *

"*The Canadian Nurse* has an assured position and a mailing list of over 1,300, stretching from the Atlantic to the Pacific, and indeed around the world."

* * *

"The Brockville Graduate Nurses' Association, judging from the enthusiasm evinced by its members, has come to stay. They began with seven members last November. Now they have twenty-two enrolled."

## M.L.I.C. Nursing Service

*Julie Lefrançois* (St. Sacrement Hospital, Quebec) has been transferred from Montreal to the Quebec City nursing staff.

# Nursing Profiles

**E. Frances Upton, R.R.C.,** the exuberant, hearty executive secretary-registrar and official school visitor with the Association of Nurses of the Province of Quebec, has given up part of the heavy load she has carried since 1929. Fortunately, her colorful personality will still add a glow to nursing affairs in the province for some months to come, since Miss Upton has consented to continue her visits to the English-language schools of nursing for the time being.

Irish to the core, Miss Upton was born and educated in Montreal. She graduated in 1908 from the Montreal General Hospital, thoroughly imbued with the tradition of service. She served successively as superintendent of a private hospital and as assistant superintendent of the Montreal Maternity Hospital until, at the outbreak of hostilities in World War I, she volunteered for military service and spent four and a half years in England, France, and the Middle East. She was with No. 1 Canadian Stationary Hospital at Wimereux where the first gas cases of the war were taken for treatment in 1915. Shortly afterwards, she was sent to the Island of Lemnos, where the sick and wounded were cared for during the ill-fated Gallipoli campaign. Miss Upton was mentioned in despatches for her work there. After a further year and a half at Salonika she was recalled to England and was serving at Bramshott Camp when the Armistice was signed. She returned to Canada in 1919.

One very happy experience of the war was her presentation to Queen Alexandra at Marlborough House following her investiture with the Royal Red Cross by King George V at Buckingham Palace.

E. Frances Upton

Laid low with a recurrence of the malaria she had contracted during her Mediterranean duties, it was not until 1921 that Miss Upton returned to civilian nursing duties. At that time she became superintendent of nurses at the Sherbrooke (Que.) Hospital where she reorganized the nursing service and initiated a sound educational program.

Looking for new worlds to conquer, Miss Upton enrolled in the McGill School for Graduate Nurses and received her certificate in administration in schools of nursing in 1924. She returned to the Montreal General Hospital as assistant in the school of nursing office. Her next undertaking was the creation of a tuberculosis sanatorium out of the temporary soldiers' hospital at Ste. Agathe des Monts. Within two months she had established the first tuberculosis course in Canada for graduate nurses.

When plans for the sixth quadrennial congress of the I.C.N. in 1929 were made, Miss Upton was selected for the post of executive secretary of the important Arrangements Committee. Her demonstrated organizing ability led immediately to the important duties she has so ably accomplished through the years. The fact that she was fluent in French as well as in English and her willingness to see the points of view of both groups have enabled her to weld the nurses of Quebec into a common association.

Ready to fight hard for a just cause, passionately devoted to nursing and the highest ideals of the profession, Miss Upton has earned herself a very special place in the affection and esteem of her fellow nurses everywhere. This appreciation of her worth was reflected in the award of the Mary Agnes Snively medal by the Canadian Nurses' Association in 1942. Her nation-wide influence will continue to be felt through her activity as chairman of the special C.N.A. Committee on Nursing Ethics. Miss Upton says she does not plan to "retire" from active interest and work as long as her legs will carry her. We hope that they will keep her whizzing around for a long time to come.

Moving into the position of executive secretary-registrar, with the A.N.P.Q., is **Margaret Mary Street.** A graduate in arts from the University of Manitoba, and of the Provincial Normal School in Winnipeg, Miss Street taught in high schools in that province for four years before entering the school of nursing of the Royal Victoria Hospital, Montreal. Her first appointment following graduation in 1936 was as instructor at St. Joseph's Hospital, Victoria. Later she became assistant night supervisor in the Vancouver General Hospital. After securing her certificate in teaching and supervision from the McGill School for Graduate Nurses, she became instructor in the Misericordia Hospital, Winnipeg. In 1943 she was appointed executive secretary of the Manitoba Association of Registered Nurses. Immediately prior to her new appointment, Miss Street was a clinical supervisor at the Royal Victoria Hospital.

Miss Street has an excellent grasp of present-day problems in nursing. She has an analytical mind which enables her to penetrate to the heart of a situation readily. The A.N.P.Q. is fortunate in obtaining the services of a nurse who is so well qualified for the exacting duties and demands of this office.

*The King Studio, Vancouver*

MARGARET M. STREET

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Ever since she was demobilized from the R.C.A.M.C., **Suzanne Giroux, R.R.C.,** has been on the executive staff of the A.N.P.Q. in the capacity of school visitor to the French schools of nursing. Born and educated in Trois-Rivières, Que., Miss Giroux graduated from Notre-Dame Hospital, Montreal, in 1926. Her preparation was augmented by courses at the McGill School for Graduate Nurses and at the University of Montreal. For three years she was assistant superintendent of nurses at the Normand and Cross Hospital, Trois-Rivières, followed by four years as instructor at Notre-Dame. In 1935, Miss Giroux became superintendent of nurses at l'Hôpital St-Luc, Montreal. She enlisted in 1942 and was principal matron of No. 17 Canadian General Hospital, stationed in England. She was awarded the Royal Red Cross at an investiture at Buckingham Palace in 1944.

Miss Giroux's skill in translation has proven invaluable both in the preparation of pamphlets for the provincial association and in bringing selected parts of *The Canadian Nurse* to the French-speaking nurses. For her many contributions to nursing, she was honored by being one of three graduates to receive a special medal cast to commemorate the golden jubilee of the Notre-Dame Hospital last year. In true French fashion, Miss Giroux is skilled in cookery; she is an omnivorous reader. Most of all, she delights in bright sparkling conversation.

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**Elsie Caroline Ogilvie** is a new member of the faculty of the McGill School for Graduate Nurses. She was appointed as lecturer and is directing the course in supervision in psychiatric nursing. Miss Ogilvie secured her certificate in hospital administration from McGill in 1928, nine years after her graduation from the old Grace Hospital, Toronto. Private duty nursing was her first form of service. After a brief period of staff work at her alma mater, Miss Ogilvie became assistant director of nursing in the Neurological In-

ELSIE OGILVIE

MARJORIE HUDSON

stitute, Columbia Presbyterian Medical Centre, in 1929. Six years later she went to the Institute of Living, Hartford, Conn. From 1937 to 1945 she was director of nursing there. Recently she completed a survey of nursing needs in the mental hospitals across Canada as consultant in mental health nursing with the Department of National Health and Welfare. Dressmaking for indoor relaxation, canoeing and riding for outdoors, keep Miss Ogilvie busy in her leisure hours.

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**Margaret G. McPhedran** is the most recent appointment to the staff of the demonstration being conducted at the Metropolitan School of Nursing, Windsor, Ont., teaching the science subjects. Born and educated in Petrolia, Ont., Miss McPhedran graduated from the Charlotte E. Englehart Hospital there in 1931. She received her certificate in teaching and supervision from the University of Toronto School of Nursing in 1934 and her diploma in nursing education in 1947. In the interval she served as instructor at the Moose Jaw General Hospital for four years and the Sarnia General Hospital for five. She was on the faculty of the School of Nursing at the University of Toronto as lecturer in nursing immediately prior to her present appointment. Miss McPhedran turns to reading and music for relaxation.

*Australian Official Photo*

GWENDOLEN BURBIDGE

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**Marjorie Agnes Hudson** has been appointed director of nursing services with the New Brunswick Division of the Canadian Red Cross Society. A graduate of the Royal Victoria Hospital, Montreal, in 1945, Miss Hudson completed her B.Sc., in nursing, at the University of Western Ontario, London, in 1946. She joined the staff of the public health unit in Timmins, Ont., from which she resigned to take up her new duties. Miss Hudson is very interested in dramatics and is an active member of the Theatre Guild in Saint John. One of her hobbies is collecting first editions of biographies. She also enjoys many forms of handicraft.

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**Dorothea McCaragher** received the award of the Order of the British Empire for distinguished service in the missionary nursing field in Tanganyika Territory. A graduate of the Montreal General Hospital in 1924 and of the McGill School for Graduate Nurses in 1927, Miss McCaragher was with the Montreal Child Health Association until 1930. She was granted a Laura Spellman Rockefeller scholarship for child study in New York and at the University of Minnesota. Having served with the Universities' Mission in Central Africa she is now stationed in Zanzibar.

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**Gwendolen Burbidge** has the unique distinction of being the first Australian nurse to receive a fellowship from the Rockefeller Foundation. It provides for eight months' study in nursing education, part of which will be taken at the University of Toronto, the balance in the United States. Miss Burbidge graduated from the Royal Melbourne Hospital and the Women's Hospital, Melbourne. She took post-graduate work at the Hospital for Sick Children and at St. Thomas's Hospital, London, receiving her diploma from

the University of London. She has been matron of Queen's Memorial Infectious Diseases Hospital, Melbourne, for the past ten years. For years, Miss Burbidge has worked for the establishment of an Australian post-graduate school of nursing.

**Annie Head,** who graduated in 1905 from the Public General Hospital, Chatham, Ont., was made the first life member of her alumnae association at a recent ceremony. Actively engaged in nursing until five years ago, Miss Head still gives part-time service in the nursery. Maternity nursing has been her special joy and she has acquired great skill in the care of newborn infants. Miss Head has demonstrated her interest in the alumnae association and its activities through seven years in the presidency. Her many hobbies and wide range of interests keep her in close touch with the life of the community as well as developments in her own special field and nursing in general. This well-deserved tribute has given great pleasure to her many friends.

**Edna L. Dickson** has retired after twenty-seven years of faithful service at Lancaster (D.V.A.) Hospital, Saint John, where she has been matron since 1937. Born and educated in Hammond River, N.B., Miss Dickson graduated from Wellesley Hospital, Newton, Mass., in 1914. She enlisted with the Canadian Army Medical Corps in 1916 and served in France with No. 3 Canadian General Hospital. Soon after her return to Canada she joined the staff of Lancaster Hospital. Much credit for her efficient administration during and following World War II is given to Miss Dickson. She has always made the welfare of hospitalized veterans a matter of personal concern. She will reside at the old family home at Hammond River.

**Dr. Helen MacMurchy, C.B.E.,** who was the first editor of *The Canadian Nurse*, was honored on January 23, 1949, when Hobart and William Smith Colleges in Geneva, New York, held a special convocation. The occasion was the centennial anniversary of the graduation of Elizabeth Blackwell, the first woman to receive the degree of doctor of medicine from a recognized medical school. Centennial citations were presented to ten outstanding women physicians, nominated by deans of medical schools to represent all the worthy successors of Dr. Blackwell.

ANNIE HEAD

Dr. MacMurchy, who graduated from the University of Toronto in 1899, was chief of the federal Division of Child Welfare for thirteen years. During this time she initiated the programs which have been instrumental in reducing the maternal and infant mortality rates. Dr. MacMurchy is now eighty-six years of age and lives in Toronto.

DR. HELEN MACMURCHY

Thank God every morning that you have something to do that day which must be done whether you like it or not. Being forced to work and to do your best will breed in you a hundred virtues which the idle never know.

— CHARLES KINGSLEY

# In Memoriam

**Christina Cameron Murray,** director and professor in the University of Wisconsin School of Nursing, died suddenly in Madison, Wisconsin, on December 4, 1948. Born in Fredericton, she obtained the B.A. degree from the University of Saskatchewan in 1917 and later taught in Saskatchewan for two years. She graduated from the Royal Victoria Hospital, Montreal, in 1924, and after a course at the McGill School for Graduate Nurses she went to the University of Wisconsin as the nursing arts instructor in the newly organized school of nursing there.

In 1930, Miss Murray returned to Canada to become an instructor at the Ottawa Civic Hospital. In 1934 she was awarded a scholarship by the Canadian Nurses' Association for post-graduate study at Bedford College, London. After her return to Canada she was an instructor at the Royal Jubilee Hospital, Victoria, until 1938 when she was appointed to the University of Wisconsin.

Miss Murray was active in district, state, and national nursing organizations in the United States and at the time of her death was chairman of the membership committee of the Association of Collegiate Schools of Nursing. In the University of Wisconsin she was highly regarded as an administrator and as a very able teacher.

CHRISTINA MURRAY

**Cora (Kirby) Arnold,** who graduated from Memorial Hospital, St. Thomas, in 1924, died in Barrie, Ont., on January 30, 1949. Mrs. Arnold had been in poor health for the past year.

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**Mary Cameron,** a graduate of Englehart Hospital, Petrolia, Ont., and a post-graduate of Grace Hospital, Detroit, died on January 17, 1949, after a lengthy illness. Miss Cameron was on the nursing staff in the schools in Windsor, Ont., for many years.

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**Mary J. Campbell,** who graduated from the Toronto General Hospital in 1904, died in Toronto on January 22, 1949. Miss Campbell had worked on the staff of several United States hospitals and latterly had engaged in private duty.

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**Alice M. Cooper,** who graduated from the Montreal General Hospital in 1912, passed away in her sleep on January 23, 1949. A veteran who saw service with the C.A.M.C. during World War I, Miss Cooper had been engaged in private duty in New York for the past twenty-five years.

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**Bessie (Fawcett) Fullerton,** who graduated from the Chipman Memorial Hospital, St. Stephen, N.B., died suddenly in Sackville on January 18, 1949, at the age of twenty-eight.

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**Mary Ellen Hattie,** a graduate of the Ottawa General Hospital, died in Antigonish, N.S., on January 1, 1949, at the age of forty-two. Miss Hattie was on the staff of the Cornwall (Ont.) General Hospital for some time. Later, and until she became ill a year ago, she was assistant supervisor at Cobourg (Ont.) General Hospital.

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**Eva (Hacker) Kennedy,** who graduated from St. Michael's Hospital, Toronto, in 1920, died in Ottawa on October 23, 1948, after a prolonged illness.

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**Nellie M. Lewis,** who served as a nursing sister with the C.A.M.C. during World War I, died in Montreal on January 27, 1949.

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**May (Kennedy) Monkhouse,** who grad-

uated from St. Michael's Hospital, Toronto, in 1900, died in Toronto following a few weeks' illness.

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**Mary Poxon,** who graduated in England in 1918 and worked in western Canada and in Montreal, died on January 24, 1949, at her home in England whence she had returned in 1947.

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**Anne Baldwin Reid,** a graduate of Jeffery Hale's Hospital, Quebec, died suddenly following a heart seizure in Moncton, N.B., on January 17, 1949. Miss Reid was formerly supervisor of the maternity ward of the Moncton Hospital.

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**Harriet Sutherland,** who completed her training at the old Montreal Maternity Hospital in 1899, died in Montreal on January 27, 1949, in her seventy-sixth year. Miss Sutherland had assisted in the Graduate Nurses' Registry for many years.

**Elizabeth Thomas,** a graduate of St. Joseph's Hospital, Victoria, who served during World War I with No. 5 Canadian General Hospital in Salonika, died in January, 1949, after a long illness.

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**Mary Teresa (Lynch) Wall,** who graduated from the Victoria General Hospital, Halifax, in 1908, died in Antigonish, N.S., on January 11, 1949, following a long illness. Mrs. Wall had received the Belgian Elizabeth Medal for her outstanding service with the C.A.M.C. during World War I.

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**Amy C. Worsey,** a 1916 graduate of the Royal Jubilee Hospital, Victoria, B.C., died in Vancouver on January 15, 1949. Miss Worsey served with the Q.A.I.M.N.S. during World War I at Netley, Seale and Hague Hospitals in England. Since 1923 she had been a member of the staff of Shaughnessy Hospital in Vancouver. She will be sadly missed by her friends and fellow-workers.

## The Edith Cavell Chapter, I.O.D.E.

An interesting example of how nurses can participate in community activities is to be found in the Edith Cavell Chapter of the I.O.D.E. in Montreal. This chapter was originally formed in December, 1915, as a tribute to the gallant nurse. Nurse Cavell's words, "Patriotism is not enough," serve as the motto of this chapter.

Since its inception, membership in this chapter has been open only to graduate nurses. Hospitals all across Canada are represented. The majority of the members are engaged in active nursing though some are now married or retired. The chapter is known for its spirit of harmony and the co-operation between its members. It is keenly interested in all I.O.D.E. work, willing to do its share and more, and contributing generously in time and money as required.

Monthly meetings are alternated, morning and evening, thus making it possible for all members to attend a meeting at least every two months. The special project of this group was its adoption of the veterans at the D.V.A. tuberculosis hospital at St. Hyacinthe. The members make regular visits to the hospital, distributing numerous gifts. In addition, they take a personal interest in the more seriously ill patients and their families. The necessary equipment for various courses and businesses was provided.

Other activities include the adoption of a school. A library was presented to it last autumn. Contributions have been made to scholarships and bursaries for the assistance of worthy students. Welfare work included sending children to summer camps, providing Christmas dinners for aged folk, etc. A large number of garments were made for European relief.

## Popularity Test

If you feel you are not as popular as you would like to be, check on (1) the sincerity of your smile, (2) the warmth of your handclasp, (3) the neatness of your appearance, (4) the tolerance you have of another's opinion, (5) the gentleness of your voice, (6) the importance you place on keeping your promises, (7) the length of your temper, (8) the eagerness to increase your interest and, above all, (9) the interest you display in the welfare of others.

— *Personews*

# Trends in Nursing

*Average reading time — 12 min. 48 sec.*

## Committee on Educational Policy

The Provisional Committee on Evaluation of Schools of Nursing reported on the progress made by the Canadian Conference of Catholic Schools of Nursing in their study of evaluation methods as outlined by Father Bertrand, president of the Catholic Hospital Council of Canada:

(1) That the Canadian Conference of Catholic Schools of Nursing had been established as a branch of the Catholic Hospital Council, which financed its formation, but which does not interfere with the activities of the Conference. (2) That the Canadian Conference of Catholic Schools of Nursing commenced to set up an evaluation program for Catholic schools of nursing, in order to help the schools to improve their educational programs and to secure greater uniformity in the educational programs offered by these schools. (3) That evaluation is the first step toward accreditation of schools. It differs from accreditation in that it does not classify schools as belonging in definite categories of excellence or mediocrity and its results are not published. Only the school which has been evaluated is given the report of the findings; and this report should assist the school to remedy weaknesses and to strengthen its total program. Father Bertrand gave as his opinion that accreditation might be expected to grow naturally out of the program of evaluation, after the latter had been in operation for eight or nine years. (4) That the procedure followed in initiating this program of evaluation was briefly as follows: (a) Visits to the United States where existing programs of accreditation and evaluation were studied. (b) Evaluation examiners from the States were invited up to confer with and instruct examiners selected by the Canadian Conference of Catholic Schools of Nursing. (c) An Evaluation Council was set up to receive the reports of school examiners. (d) These two groups (i.e., examiners and Council) were educated as to the principles and techniques by institutes at which were present representatives from the Sisterhoods from all parts of Canada. (e) A pilot evaluation survey was made of selected schools of nursing from all parts of Canada (24 schools in all). (f) Following this survey, intensive study continued concerning evaluation techniques, records, etc. This study took two full years. From the pilot survey, criteria were formulated which would form a guide to further surveys. (g) An institute was held (December, 1948) at which the results of all the studies and surveys to date on this evaluation project were studied and analyzed, and the evaluation machinery set up as approved by the institute. (5) That it is sound policy, when inaugurating an evaluation plan, to work out the details through conferences or institutes widely representative of all sections of the country. In this way, not only are the representatives educated as to the underlying objectives, methods, and techniques of evaluation, but they return to their institutions and provinces prepared to interpret the plan locally. They are thus valuable public relations officers. Thus, a national institute for superintendents of nurses on the subject of evaluation might be one of the first steps to be taken in launching the program.

At a meeting held at Youville Institute on December 6, 1948, Rev. Sr. Denise Lefebvre, technical adviser for the evaluation program, outlined the progress made to date in the evaluation of the studies, as follows: Members of the Canadian Conference of Catholic Schools of Nursing met with school of nursing examiners and personnel from the office of the Catholic Hospital Association of the United States. Some Canadian Sisters were appointed as examiners to conduct the pilot survey of 24 selected schools. To save expense at that time, the examiners were appointed from their own regions. Each visited one or two schools, accompanied by examiners from the United States. A Board of Review was set up to receive the reports of the examiners. Evaluation materials as used in the United States plan were made available, and adapted gradually as required for use in Canada.

Now, at the end of more than two

years' study, Sister Lefebvre outlined briefly the pattern that had developed. Materials included: Preliminary questionnaire sent to schools to be evaluated; score cards; evaluation manual and statistical sheet; pattern maps; graphs showing various comparative data. The committee was greatly impressed by the meticulous care shown in this study, as well as by the evident mastery of the subject which Sister Lefebvre has gained. It was felt that this evaluation procedure, if it could be carried through as set forth, would be of the greatest value in improving the educational programs of schools of nursing and that all schools should welcome this assistance.

## Meeting of Advisory Committee

Last fall, on the invitation of the Hon. Paul Martin, Minister of Health and Welfare, the Canadian Nurses' Association appointed representatives to an Advisory Committee to the Department of National Health and Welfare with respect to the national health grants. The Advisory Committee includes representatives from the five professional groups, namely: the Canadian Medical Association, Canadian Public Health Association, Canadian Hospital Council, Canadian Dental Association, and the Canadian Nurses' Association. The Deputy Ministers of Health are the directors of the nine provincial survey committees. Representatives from these two committees (with the exception of the Canadian Dental Association) met jointly on November 24 and 25 to discuss the health survey grant from the Federal Government designed to investigate present health services and facilities, including hospitals, and to study ways and means of improving them. It was interesting but alarming to note that at the time of this meeting only one or perhaps two of the provinces had representation from the organized nursing profession on the main survey committees.

The professional organizations discussed their problems freely and the following suggestions were offered by the C.N.A.:

(1) That nurses appointed by respective provincial associations be represented on committees, in connection with health grants, whenever said committees contain other professional representatives. It was also recommended that all nurses employed in connection with health grants be appointed in consultation with the organized nursing group in the province. (2) That bursaries be available to nurses for post-graduate education; that in the hospital field they be used to prepare teachers, supervisors, and administrators; and in the public health field to prepare staff, supervisors and administrators for both official and voluntary agencies. (3) The conservation of existing professional nursing service; an increase in residence accommodation for student nurses; an increase in the number of independent schools of nursing; an increase in the number of male nurses; an increase in the number of auxiliary workers and their utilization throughout a 24-hour period. (4) An additional grant for nursing.

The following day, at a meeting of the directors of the provincial surveys, the following resolution was passed:

Whereas the problem of the provision of adequate nursing personnel is of national importance, this group recommends to the chairman that it would seem proper and desirable to use funds allocated under the health grants for Public Health Research for the purpose of conducting an adequate survey of the whole question on a national basis.

Sponsorship of a project of this nature is required by a provincial government and a representative from one of the provinces volunteered to have his government sponsor a national survey of nursing.

During the final meeting with the Minister, the decision was reached to set up a "National Consultative Committee." This committee is to be limited to national professional associations and is to be advisory to the Minister.

## Joint Committee

At a meeting of the Joint Committee of the Canadian Hospital Council, Canadian Nurses' Associa-

tion, and Canadian Medical Association held in Toronto on December 15, 1948, Mr. R. Fraser Armstrong was appointed chairman and Miss Edith Young, deputy chairman. Mr. Armstrong pointed out that the task before the committee went beyond nursing to that of the need of the people of Canada. It was, therefore, the consensus that the basis of the approach for a broad-scale study of nursing should be from the standpoint of Canadian needs. It was reported that at a meeting of the Advisory Groups and Provincial Survey Committees for the federal health grants, held in November, 1948, it was agreed by the Survey Committees to recommend provincial support of a resolution favoring the setting up of a committee to study the whole subject of nursing. The following objectives and terms of reference for a study of nursing were approved by the Joint Committee:

*Objectives:* (1) Estimation of the nature and extent of need of the citizens of Canada for nursing service of all types, professional and auxiliary, which seems likely to prevail for some years to come. (2) By means of a scientific job analysis, to outline the duties that can safely be undertaken by professional nurses and to outline the duties which may be safely performed by auxiliary nursing personnel and to differentiate between them. (3) Examination and appraisal of present methods of preparing professional nurses in schools of nursing operated by universities, hospitals, or under other auspices; as well as the preparation of auxiliary workers. (4) Examination of the desirability of operating schools of nursing on a different basis than at present. (5) Analysis of the cost to hospitals of operating schools of nursing and of the value to those hospitals of the nursing service rendered by student nurses. (6) Exploration of possible sources of financial support for the education of nurses other than those now available for this purpose. (7) Study of recruitment, needs, and practices, and such other objectives as are necessary to a full study of the problems of providing nursing care.

*Terms of reference:* That a survey committee be appointed by the Department of National Health and Welfare to be formed from representatives nominated by the Canadian Nurses' Association, Canadian Hospital Council, Canadian Medical Association, and representatives of education and the public: (a) That the chairman be a prominent educationalist or representative of the public known to be interested in this broad subject; (b) that he be appointed after consultation with the National Consultative Committee.

It was agreed that the minutes of this meeting, including the objectives and terms of reference, should be made available to the different organizations represented at the Joint Committee meeting, in order that they could be submitted to their respective executives for examination and study, following which approval or disapproval should be sent to the secretary together with their opinions.

## Committee on Finance

On presentation of proposed budgets of national committees to the Committee on Finance, it was found that the $1,000 grant to these committees would be insufficient to cover the costs of one year, let alone the biennium. It should be pointed out that these costs must include travelling expenses as well as costs of projects undertaken. With the exception of the Educational Policy Committee, none of the committees was able to budget for any special projects, thus limiting the effectiveness of their work. In reviewing comparative budgets for the months since the biennial meeting, it was realized that we have not budgeted sufficiently for the item "General Travelling Expenses." The increased costs already made under this item, and foreseen for the remainder of this biennium, are due to advisory meetings in Ottawa, and to extra costs in relation to committees which may be set up for the proposed study of nursing.

It was pointed out that the C.N.A. will be in an embarrassing position if it is unable to double the I.C.N. fee for 1949. The American Nurses' Association has already doubled its fee and many other countries are taking steps to do so. On the basis of

26,000 members, this would amount to approximately $2,000, an item which was not included in our budget. The National Office has recently received notice of an increase in rent for the remainder of the biennium. This increase will amount to $450; also an item not included in the budget.

From the foregoing, it was realized that the following additional amounts, not included in the budget, must somehow be found:

A. For doubling the fee to I.C.N., 1949. $2,000.

B. For additional amounts needed by committees, $1,700.

C. For additional amounts for travelling expenses, $1,000.

D. For increase in rent, $450.

*Total*—$5,150.

It should be pointed out that in order to meet the budget as submitted to the biennial meeting in June, an amount of $5,962 would have to be taken from reserve funds. (Note—This is not allowing for A, B, C, and D above.) In order to carry on the present program without jeopardizing our reserves to a greater extent, it was recommended that the provincial associations be asked for a token grant amounting to twenty-five cents per member for the remainder of this biennium. Again it should be stated that this need is only based on the present program, and does not allow for any expansion. Therefore, in order to carry on in the succeeding bienniums, and to expand our program, it will be essential for the provinces to double the affiliation fees to the C.N.A. as recommended at the last biennial.

It was also recommended that the Executive grant authority to the general secretary to cash bonds as required to the value of $8,200 after consultation with the president and the chairman of the Committee on Finance.

### Committee on Private Duty Nursing

The committee reported that all business had been conducted by correspondence; that seven articles had been forwarded to *The Canadian Nurse* for publication; that in Ontario the community registries had conducted educational programs throughout the province which consisted of lectures followed by demonstrations of nursing procedures; that in Alberta, group nursing (i.e., two patients) was being done in three centres — Edmonton, Calgary, and Lethbridge — at a fee of $4.00 per patient, with a probable increase to $5.00 per patient; that several requests had been received for information regarding the setting up of registries.

## Orientation et Tendances en Nursing

COMITÉ DE L'EDUCATION

Le Comité Temporaire de l'Evaluation des Ecoles fit un rapport des progrès accomplis par la Conférence des Ecoles d'Infirmières catholiques. Cette conférence a fait une étude des méthodes d'évaluation tel qu'exposées par le Père Bertrand, président du Conseil des Hôpitaux catholiques du Canada:

1. La Conférence des Ecoles d'Infirmières catholiques fut formée comme filiale du Conseil des Hôpitaux catholiques, lequel supporte tous les frais de la conférence, mais sans intervenir dans ses activités.

2. La Conférence des Ecoles d'Infirmières catholiques commence à établir un programme d'évaluation pour les écoles catholiques, afin d'aider ces écoles à améliorer leur programme d'étude et afin d'obtenir plus d'uniformité dans le programme d'étude offert par ces écoles.

3. L'évaluation sera le premier pas conduisant à l'accréditation des écoles. L'éva-

luation ne classifie pas les écoles dans une catégorie définie tel qu'excellente ou médiocre et les résultats ne sont pas publiés. L'école évaluée est seule à connaître le résultat obtenu. Ce rapport aide l'école à remédier à ses faiblesses et à donner un meilleur programme d'étude. Le Père Bertrand est d'opinion que l'accréditation des écoles se fera progressivement, lorsque l'évaluation aura été faite durant huit à neuf ans.

4. Voici qu'elle a été la manière de procéder en instaurant ce programme d'évaluation: (a) Visites aux Etats-Unis où furent étudiés des programmes d'évaluation et d'accréditation. (b) Des évaluateurs des Etats-Unis furent invités à venir parler et donner des instructions à un groupe choisi par la conférence des écoles d'infirmières catholiques. (c) Un conseil ou comité d'évaluation fut nommé et chargé de recevoir les rapports des inspectrices des écoles. (d) Les principes et les techniques de l'évaluation furent enseignés aux deux groupes (Conseil et inspectrices) lors de journées d'étude, auxquelles assistèrent des représentantes de toutes les communautés religieuses du Canada. (e) Une évaluation d'essaie fut faite sur un certain nombre d'écoles dans différentes parties du pays (vingt-quatre en tout). (f) A la suite de ce relevé, une étude intensive fut faite concernant les techniques d'évaluation, la compilation des renseignements, etc. Cette étude dura deux ans. De ce relevé, des critères furent établis qui serviront de guide. (g) Des journées d'études furent tenues en décembre 1948. Le résultat des études et des enquêtes concernant l'évaluation furent analysées et les méthodes d'évaluation préconisées furent approuvées par les membres présents.

5. Il est d'une bonne politique lorsque l'on établi un plan d'évaluation d'en discuter lors de réunions et conférences, auxquelles assistent des représentants de toutes les parties du pays. De cette manière, non seulement les personnes présentes sont renseignées sur le but de l'évaluation, les méthodes et la technique, mais à leur tour elles renseignent les autres, en faisant connaître dans leur institution et leur localité le plan d'évaluation proposé.

Ces personnes deviennent d'importants officiers des relations extérieures. Donc une réunion de toutes les directrices d'infirmières du Canada où l'évaluation serait le sujet à l'étude serait l'un des premiers pas pour établir un programme d'évaluation.

A une assemblée tenue à l'Institut Marguerite d'Youville le 6 décembre 1948, la Rév. Soeur Denise Lefebvre, consultante technique du programme d'évaluation, a donné un compte-rendu des progrès réalisés à date, à savoir: Les membres de la Conférence des Ecoles d'Infirmières catholiques se rencontrèrent avec les examinateurs de l'Association des Hôpitaux catholiques des Etats-Unis. Des religieuses canadiennes furent nommées examinatrices pour faire un relevé d'essai sur vingt-quatre écoles. Pour des raisons d'économie, les examinateurs furent choisis dans la région des écoles à examiner. Chacune de ces religieuses visita une ou deux écoles accompagnée de l'examinateur américain. Un conseil fut formé et chargé d'examiner les rapports. Les formules d'évaluation employées aux Etats-Unis furent amendées de façon à pouvoir servir au Canada. Maintenant, à la fin de deux années d'étude, Soeur Lefebvre a donné un compte-rendu du travail à date, en donnant un exemplaire du questionnaire envoyé aux écoles choisies pour l'évaluation; les fiches de points; le manuel d'évaluation et des feuilles de statistique; des modèles, des courbes illustrant les différents renseignements reçus.

Le comité a été fort impressionné par le soin méticuleux apporté à cette étude et aussi par Soeur Lefebvre, qui est devenue un maître dans la matière.

Cette méthode d'évaluation de l'avis de tous aidera à l'amélioration du cours d'étude, si on continue de l'appliquer dans les écoles.

### Réunion du Comité Consultatif

L'automne dernier, sur l'invitation de l'Hon. Paul Martin, Ministre National de la Santé et du Bien-Etre, l'Association des Infirmières du Canada nomma des représentantes à un comité consultatif du même ministère au sujet des octrois de santé. Ce comité était composé de représentants de l'Association canadienne des Médecins, l'Association canadienne d'Hygiène Publique, le Conseil canadien des Hôpitaux, l'Association canadienne des Dentistes, et l'A.I.C.

Les sous-ministres des Ministères de Santé étaient présents, les directeurs des neuf comités chargés de faire le relevé de chaque province.

Il y eut deux autres réunions, les 24 et 25 novembre, quand l'on discuta de l'octroi accordé pour faire un relevé de tous les services hospitaliers et des moyens à prendre pour les améliorer.

Ce n'est pas sans un peu d'alarme que l'on constata que sauf dans une ou deux provinces,

il n'y a pas de représentante de la profession d'infirmière sur ce conseil chargé de l'enquête.

Les associations professionnelles discutèrent longuement de leurs problèmes et les suggestions suivantes furent offertes par l'A.I.C.: (1) Que les infirmières, nommées par l'association provinciale, fassent partie des comités concernant les octrois fédéraux, même si déjà il y a d'autres représentants professionnels sur ces comités. Il fut aussi recommandé que l'association provinciale des infirmières soit consultée lorsqu'il s'agira d'employer des infirmières pour les octrois de santé. (2) Que des bourses d'études soient données pour des cours post-scolaires; que dans le domaine hospitalier, elles soient employées à préparer des institutrices, des surveillantes, et des administratrices; en hygiène publique à préparer des infirmières hygiénistes, des surveillantes, et des administratrices pour les associations bénévoles et officielles. (3) La conservation des services d'infirmières présents, d'augmenter le nombre de résidences pour les élèves infirmières, d'augmenter les écoles indépendantes d'infirmières, d'augmenter le nombre d'infirmiers (male nurses), d'augmenter le nombre d'aides et étendre leur travail sur une période de vingt-quatre heures. (4) Un octroi supplémentaire pour les infirmières.

Le lendemain, à une assemblée des directeurs des enquêtes provinciales, les résolutions suivantes furent adoptées:

Etant donné qu'un nombre suffisant d'infirmières est d'une importance nationale, ce groupe recommande au président qu'il serait à propos et désirable que l'octroi, donné à titre de subvention en matière de recherches sur la santé publique, soit employé à étudier cette question sur une base nationale.

Un tel projet devant être recommandé par un gouvernement provincial, un des représentants recommanda au nom de son gouvernement. A la dernière assemblée, le ministre décida de former un comité consultatif national. Ce comité comprendra que des représentants des associations professionnelles et relèvera du ministre.

### Comité Conjoint

Lors d'une assemblée du comité conjoint du Conseil des Hôpitaux du Canada, de l'A.I.C., et de l'Association Médicale canadienne, en décembre dernier, le point de vue suivant fut exprimé: Que la tâche à entreprendre était très vaste, et qu'il fallait étudier la question des infirmières en se basant sur les besoins de la population du Canada.

Les buts de ce relevé seraient: (1) Le nombre d'infirmières et d'aides nécessaires pour répondre au besoin de la population du Canada, d'ici à quelques années. (2) Par une analyse scientifique des tâches, déterminer le travail que peuvent accomplir les infirmières et celui qui peut être accompli, sans danger, par des aides. (3) Examiner et évaluer les différentes méthodes de formation dans les écoles d'infirmières opérées par les universités, les hôpitaux, et sous d'autres auspices; faire de même pour les écoles d'aides. (4) Examiner s'il serait opportun d'apporter des changements dans la façon de conduire nos écoles d'infirmières. (5) Analyser le coût, à l'hôpital, des écoles d'infirmières et la valeur des services rendus par les élèves. (6) Etudier l'aide financière que l'on peut se procurer. (7) Etudier les méthodes de recrutements, les besoins, etc.

### Comité des Finances

Lors de la présentation des budgets des comités nationaux l'on constata qu'en attribuant même une somme de $1,000 aux comités, aucun ne pourrait réaliser les projets à exécuter. Le coût des voyages et le projet à réaliser dépassent cette somme. Cette année aucun comité, sauf celui de l'éducation, n'a pu boucler son budget et n'a pu réaliser le travail qu'il désirait accomplir.

L'on a fait aussi remarquer que l'A.I.C. serait dans une mauvaise position, si elle ne peut augmenter sa cotisation au C.I.I. L'Association des Infirmières des Etats-Unis a déjà doublé cette cotisation et l'on fait de même dans d'autres pays.

L'A.I.C. a déjà reçu un avis l'informant d'une augmentation de loyer au montant de $450. Voici quelques autres dépenses à ajouter au budget prévu pour 1949:

(a) Doubler la cotisation au C.I.I. 1949, $2,000.

(b) Montants additionnels pour les comités, $1,700.

(c) Montants additionnels pour les frais de voyages, $1,000.

(d) Augmentation du loyer, $450.

*Total* — $5,150.

Il fut décidé de demander aux associations provinciales une garantie de vingt-cinq cents par membre d'ici le prochain congrès national.

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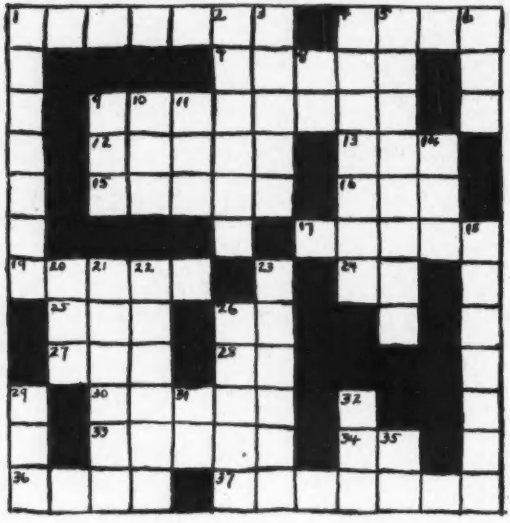
What the best and wisest parent wants for his own child, that must the community want for all its children.—John Dewey.

# Crossword Puzzle Page



## ACROSS

1. A branch of medicine which gives Dr. Brent a daily call.
4. Cicatrix.
7. An artery.
9. Sodium ethyl methyl butyl barbiturate.
12. Used to raise one to a higher level.
13. When the sterilizer runs over, the nurses–.
15. Temples or churches.
16. Anger.
17. They are cuts — but will make you dizzy if taken the wrong way!
19. 1000 cc.'s.
24. Commonly used diphthong.
25. Usually associated with 4:00 p.m.
26. Quiet ! ! !
27. It's all over !
28. 3.14159 +
30. A dactyl.
33. 28.35 gm.
34. Bone.
36. These English school-masters are just putting on.
37. Come in — and get an intestinal antiseptic.

(*Solution on page 308*)

## DOWN

1. Instrument used in 1 across.
2. Hydrophobia.
3. It belongs to you.
4. Vigor — all nurses have it.
5. Count them as you eat them.
6. Nurses are usually in this at the end of the month!
8. Right (abbr.)
9. We constantly dread seeing this notice!
10. A Greek letter.
11. An article in great demand.
14. We are full of this every morning at 6:00 a.m.!
18. This act is carried out with 1 Down.
20. A follower (suffix).
21. Fibrous cord by which a muscle is attached.
22. Bone of the forearm.
23. What *all* hospital nurses do to their footgear *every* day!
26. That which gives flavor or zest.
29. Try — three times a day.
31. Graduate Nurses.
32. Pedal digit.
35. Senior (abbr.).

*Student Nurses*

# Subarachnoid Hemorrhage

NANCY WRIGHT

*Average reading time — 13 min. 36 sec.*

ON OCTOBER 26, 1947, Baby Jones was admitted to the children's ward. He was in a deep coma with the combination of a slow pulse (60—especially slow for a baby, whose average pulse is 120), and rapid respirations. His temperature was 97° which is slightly afebrile. Several minutes later convulsive movements of the limbs and head began, with arching of the spine. These lasted approximately half a minute. At the same time his respirations became more and more rapid and shallow. When the convulsions were over breathing became easier, and the baby slept and cried alternately for short periods.

The doctor's diagnosis was subarachnoid hemorrhage with complicating hydrocephalus. In this condition the blood from the venous sinuses of the brain breaks through the inner layer of the dura mater and through the arachnoid membrane into the subarachnoid space, irritating and blocking the villi of the arachnoid membrane. Through these villi, which project into the venous sinuses between the two layers of the dura mater, cerebrospinal fluid is normally absorbed into the blood stream. As a result of the breakage and irritation, the fluid cannot get through and so it collects, with the blood which has broken through, in the subarachnoid space. The pressure of this increased fluid content of the subarachnoid space and spinal canal (which are continuous) causes severe headache and may be so great as to cause actual destruction of brain cells. Other symptoms are irritability and a typical, sharp, high-pitched cry, with stiffening of the body. Some of the signs to be watched for are: convulsions, squint, sluggish pupils, slow pulse, albuminuria, glycosuria, and blood in the cerebrospinal fluid. In this patient the condition was thought to be caused by the bursting of an aneurysm. The rupture of a congenital aneurysm of one of the cerebral blood vessels is a common cause of subarachnoid hemorrhage.

At the time of admission to hospital Baby Jones was three and a half months old. Both parents seemed of good intelligence and were very fond of the child, who was their first baby. Although fretful from birth, (which suggests a slight degree of meningeal irritation right from the start), the baby was attractive in appearance and seemed to be of normal intelligence and development.

## CASE HISTORY

Ten days before the date of term the mother had picked up a five-year-old child who had fallen downstairs and carried him upstairs to his parents. That day the membranes ruptured, (unusual at that stage in a primipara), and the patient was taken to hospital where labor was induced and the baby finally delivered with low forceps. At birth the child appeared normal except for a peculiar, high-pitched cry at times. He was breast-fed and was gaining well when discharged at ten days.

Progress up to two months was fair except for sudden cries at night, high-pitched and piercing in character, and associated with an upward rolling of the eyes and wrinkling of the forehead. The baby was always hypersensitive and never liked being handled.

At two months he had a convulsion, characterized by a stiff neck, a sharp, high-pitched cry, continuing with stiffening of the

Miss Wright is a student nurse at the Royal Jubilee Hospital, Victoria, B.C.

body, clonic movements of the extremities, and upward rolling of the eyes. He was then admitted to hospital, where convulsions were frequent, lasting two to five minutes each time. A spinal tap done on admission was bloody. One done several days later was clear with only a few red cells and some increase in protein (there is 0.03% protein in healthy spinal fluid). The child's condition improved and he was discharged "not yet diagnosed," but with the opinion that it must have been some type of meningitis.

On returning home the child developed diarrhea, also vomiting after each feeding, until one pound in weight was lost. He was again hospitalized for several days and his feedings regulated. During this admission the child had no convulsions but it was noted his head was enlarged (17 inches in circumference—the average circumference at this age is 15½-16 inches). He was discharged from hospital on October 19, 1947.

On October 24 he had another convulsion. Seen almost an hour later, he was found to be screaming with pain, twitching of both arms and legs was severe, and the anterior fontanel felt full but not tense. A sedative was given and the child became quiet. For some days prior to this attack, all feedings had been vomited with projectile force and the child had lost weight and become listless. He seemed to improve and then on the morning of the 26th another convulsion occurred, followed by unconsciousness. He was admitted to hospital for the third time, in the condition already described.

He lay at first with his eyes half open as if semi-conscious or completely unconscious. It was obvious that he was acutely ill. He was phlegmatic and apathetic between convulsions, which were frequent, and he was also very often fretful. His skin was grey in color, cold and clammy. His muscles were flabby. His head was further enlarged, being nearly 17⅝ inches in circumference. The anterior fontanel, which should at that age have been soft and level with the bones of the head, was bulging and abnormally wide, the cleft being palpable half-way down the forehead and the sides of the head. All reflexes were sluggish, including the pupils, which however were equal. The spine was normal but the feet were flat. The baby's weight was 11 pounds, 14 ounces, whereas the average weight for a baby of this age is 13-14 pounds. He was on formula of 6½ ounces, five feedings daily, with a small amount of pablum offered twice a day.

A spinal puncture was done on admission, 10 cc. of dark red fluid being withdrawn. This showed a large quantity of gross blood. Microscopic examination revealed a red cell count of 540,000 and some pus, the latter by direct smear. The pressure was extremely high. A culture showed no bacterial growth. Later on the same day another 10 cc. were withdrawn. The fluid was still dark red. The urinalysis was significant in that it showed ½% sugar. A routine throat swab was also taken and cultured but this showed nothing more than a moderate growth of usual flora and so was not significant except from a negative point of view.

From the day on which Baby Jones entered hospital until November 1 his condition grew steadily worse. At first when he was not sleeping he was almost invariably crying—a sharp, shrill cry. Convulsions were increasingly frequent and continued for lengthening periods, until there was hardly any interval of time between them. Both sides appeared to be equally affected. The convulsions became noticeably stronger in character when the baby was disturbed for feeding or changing. His formula and extra fluids were taken well the first day, but were often followed by a good deal of regurgitation and in one instance by projectile vomiting. As his condition grew worse he took less and less formula until he finally kept his jaws clenched and seemed unable to swallow.

His temperature during this stage varied considerably, finally rising to 105°. His pulse, which was at first slow but regular and of good quality, became gradually weaker and irregular, increasing in rate to 200. His respirations during most of this period were shallow and rapid, finally reaching 100, at which time they were also very wheezy owing to the collection of mucus in his throat and chest which caused definite râles. Voiding decreased in amount in proportion to the decrease in fluid intake.

Interstitials of 50 cc. of normal saline were commenced, being given twice a day to prevent dehydration. Spinal punctures were ordered to relieve the pressure of spinal fluid and blood on the meninges as indicated by the convulsions and the bulging of the fontanel. These were to be done at the onset of each convulsion, the idea being to relieve pain and to prevent deterioration of brain cells through pressure. Considerable improvement was noted after the first of these,

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on the day of admission, but the following day the fontanel still bulged and the pressure was still high, indicating further hemorrhage. There was a marked arching of the spine all of this time and any attempt at flexion caused severe pain (a characteristic sympton of meningeal irritation). The baby's color was poor and he lay with his eyes wide open most of the time. Nembutal gr. ½ was given frequently to relieve spasticity. (This is a fairly strong hypnotic dose for a baby of three and a half months.)

At the end of this period the eyeballs and fontanel were sunken from dehydration (and in the case of the latter from the absorption of the products of the hemorrhage) and lack of nourishment. The child perspired profusely and his extremities were cold. His limbs, which twitched almost continuously, were limp for the short, intervening periods. His eyes also moved in a jerky manner (nystagmus) almost continuously. For approximately four days he lay in this weakened condition, not even crying. Hemorrhage had apparently ceased, since the fontanel no longer bulged, but the convulsions continued and he made little or no progress. On October 29, a glycerin suppository was given as his bowels had not moved since admission. A large amount of dark brown stool was passed. Two days later there was a large amount of black tarry stool, which seemed to indicate a generalized loss of muscle tonus in the walls of the blood vessels with resulting hemorrhage into the intestine, a condition sometimes found immediately prior to death. It was thought, therefore, to have no direct bearing on the subarachnoid hemorrhage. An attempt at spinal puncture the previous day had revealed a thick, jelly-like substance, dark red in color, which adhered to the end of the needle and could not be aspirated. The doctor gave no hope of the baby's recovery.

On November 1, however, there was a marked improvement. Several times that day Baby Jones gave his sharp, high cry. His stools from then on became more normal in color (brown), though curdled and foul-smelling. He began to take from 3-5 ounces of formula at a feeding. Spasticity was still marked but the arching of the spine was only slight. From then on he continued to improve gradually. Spasticity ceased in a few days but he still arched his back. He took his formula well, stools became normal, and regurgitation ceased. His cry became more normal but not entirely so. The head and fontanel remained enlarged but the latter was no longer bulging nor was it abnormally depressed. Color improved and temperature, pulse, and respirations became normal, averaging around 99°, 120, 30. Much of the baby's hair fell out during early convalescence but soon grew in again.

The only remaining abnormalities were the enlarged head, the slightly strange cry and fretfulness. His weight on November 28, when he was discharged from hospital, was 12 pounds, 7 ounces, which showed a satisfactory gain though still not a normal weight. The head circumference was 17¾ inches. It is to be hoped that the head will not grow much more so that in time, as the body grows, the head will be average size in proportion to the body. The size of the head at discharge was equal to that of the average child of one year.

### Résumé of Treatment

The plan of treatment during this illness, as already indicated, consisted of spinal punctures for relief of pressure and sedation (nembutal suppositories gr. ½) to quieten the child during spasm by inducing sleep, which also saved him from suffering pain. Due to its slightly depressing effect on the circulatory system, nembutal would also aid in lessening hemorrhage and in decreasing the pressure of the cerebrospinal fluid. Synkamin (vitamin K) 1 cc. was also given every day for eighteen days to aid in blood clotting and so reduce the amount of hemorrhage. Interstitials were used to supplement feedings in an attempt to prevent dehydration and to maintain life while nothing was being taken by mouth. Normal saline was given because by introducing into the tissues fluid which is of the same concentration as the blood there is no interference with normal osmosis.

When the acute stage was over and normal feedings were resumed, the usual additions and supplements were made to the formula, which was itself increased and strengthened as growth and development demanded. Ascorbic acid 50 mgm. twice daily was given to provide vitamin C, iron and ammonium citrate to supply iron, and

pablum as an introduction to solid foods. Later, pureed vegetables and fruits were added gradually in small amounts and one teaspoonful of egg yolk daily to provide vitamins A and D, calcium, phosphorus and iron, also a finely emulsified and, therefore, easily digested form of fat, as well as complete protein.

Diet in this case was not directly related to the disease but nutrition became an important factor during the acute stage when feeding was difficult. The use of a Brecht feeder proved helpful for awhile since it required less strenuous sucking by the baby. When spasticity increased, though, he would merely clench his gums over the nipple and no amount of pressure on the rubber bulb at the end of the feeder could force the milk through. An eye-dropper was then used with fairly good results. The chief difficulty in each of these methods was to avoid the aspiration of formula. The nurse had to make certain before feeding that the baby could and would swallow. Occasionally, the swallowing reflex appeared to be absent and oral feeding was not attempted. Sterile water was given between feedings to offset the fluid loss through regurgitation and the low fluid intake owing to refusal of formula. Extra fluids were desirable during the febrile stage to supply the large amount used by the increased metabolism. During the convalescent stage diet was no problem. New foods were taken well. The giving of medications did not afford any unusual difficulties. The nembutal suppository was occasionally expelled immediately after being inserted, in which case it was repeated. Even when badly dehydrated the baby had sufficient muscle for the synkamin to be given without undue difficulty.

All treatments, including bathing, changing, taking of temperature, etc., were done as thoroughly and as quickly as possible to avoid undue exposure at a time when resistance was unusually low and to allow the baby as much rest as possible. Special care of the skin was a very important feature of the nursing care because poor nutrition, combined with excessive perspiration, made the baby's skin particularly susceptible to pressure sores. These were prevented by regular cleansing of the skin at least once a day with soap and water, oiling of the creases and buttocks with oil and the use of zinc oxide powder on the buttocks, mixed to a paste with the oil. The buttocks were also washed with soap and water after each bowel movement and zinc oxide and oil reapplied. Wet diapers were changed as soon as possible and the skin again oiled and powdered. The oil that was used was mild and non-irritating, and formed a protective coating over the skin to prevent it from being irritated. For actual cleansing of the skin, soap and water were found to be more effective. It was necessary, while the baby was running a high temperature and not feeding normally, to give special mouth care to overcome dryness of the mucous membrane from dehydration, to prevent cracking, and to discourage the growth of pathogenic bacteria in the mouth. For this purpose a mixture of glycerin, lemon, and boric acid was used to swab out the mouth and vaseline was applied to the lips.

The main procedures used were the spinal puncture and the interstitial, or hypodermoclysis. The first of these was done, of course, by a doctor. The nurse was responsible for setting up the sterile field, holding the child in position so that the lumbar vertebrae were well separated, labelling the specimens and taking them to the laboratory; and noting the pressure (when a manometer was used), the character of the fluid, and the general condition of the patient. The interstitials were given entirely by the nurse. Most of them were given by the open-drip method but some were given using a syringe only. The solution had to be injected very gradually to prevent the tissues from becoming too edematous. When this did occur the injection was stopped temporarily to allow the excess fluid to be absorbed. The procedure caused surprisingly little pain to the baby, once the needle was in place,

providing the solution was not allowed to run too fast.

As already stated, Baby Jones had always been an irritable baby. As a result he had caused his mother much anxiety and loss of sleep, besides being a source of great disturbance to other people in the house. In hospital, too, this proved a problem. Baby Jones could not be allowed to cry too long because he would waken the other babies in the nursery, which would result in even greater disturbance. Quite apart from the noise he made it was felt that the fretfulness and restlessness should be dealt with because it was an evidence of pain. Therefore when no more could be done to relieve the cause of the crying and no nursing measures were effective, a suppository of nembutal gr. ½ was given. This was found to be necessary on an average of twice in every twenty-four hours during the first few weeks, and then gradually less until it was given only every few days.

On November 28 Baby Jones was taken home but was brought back into hospital again the same evening. He had cried almost continuously and his mother was nearly frantic. The noise of construction near the home had apparently disturbed him and possibly aggravated the condition of irritation. He continued to be cared for in hospital until January 3, 1948, when he was finally discharged. He had improved slightly in the five weeks since the first attempt to take him home. The mother was given a supply of suppositories by the doctor but she very seldom found it necessary to use them. After being at home for several weeks, mild clonic movements of the extremities began to recur. It was hoped that the pressure of the cerebrospinal fluid was not increasing due to lack of absorption through the villi of the arachnoid membrane, some of which may have been permanently damaged, or due to further hemorrhage which may have occurred. There was no evidence of bulging of the fontanel.

Arrangements were made for the baby to be treated through a special clinic. It was felt that this gave him

the best possible chance of improvement. The degree of permanent paralysis or mental subnormality would depend largely on the extent of atrophy of brain cells. The scar tissue cannot be replaced by normal tissue but it can often be removed with good results.

Mrs. Jones's fears of caring for her baby were largely overcome by the teaching given her by her doctor. She learned to use the nembutal suppositories wisely to relieve pain and spasticity.

The study of this case made me realize the folly of disregarding any symptom however slight. Even though further investigation may reveal no diseased condition or abnormality at the time, the symptom may later prove to be of significance, as did the strange, high-pitched cry of this baby.

## Nutritious Nuisance

Dandelions have their nuisance value, but they have a nutritional value as well. They are high in vitamin A, vitamin C, and iron. Dandelion greens are delicious when prepared properly. They should be washed thoroughly and boiled from five to ten minutes in salted water. The proper mixture is one-half teaspoon of salt to a pint of water. Fresh beet greens and turnip tops can be cooked and used in the same way.

## Metropolitan Health Committee, Vancouver

**Appointments:** *Elizabeth Leighton* (Royal Jubilee Hospital and University of British Columbia public health course); *Winnifred Farrell* (Royal Columbian Hospital, New Westminster, and U.B.C. p.h.n. course); *Thomasina Allen* (St. Paul's Hospital, Vancouver, and U.B.C. p.h.n. course); *Rachel Doull* (Regina General Hospital and McGill University p.h.n. course); *Winona (Carrothers Embleton* (B.A.Sc., U.B.C.); *Nora Bell* (Calgary General Hospital and U.B.C. p.h.n. course); *Dorothy Hodgert* (Vancouver General Hospital and U.B.C. p.h.n. course).

**Resignations:** *Vera Sangster, Mabel Donovan, Anita Wong, Corinne Eriksson.*

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## Effective Remedy

A boy, one month old and weighing just over seven pounds, was received at the pediatric department of a hospital in the south of England on April 25, 1947. On April 23 he had begun to whoop, suffering continuous paroxysms, vomiting, and recurrent periods of apnea. As a result of treatment with a new remedy, vomiting stopped the same day, apnea two days later, and the paroxysms on May 7. Recovery was uneventful and the child was able to leave the hospital on May 22, now weighing eight pounds, eight ounces.

This is an extraordinary case record, for whooping cough usually lasts several months, and the treatment applied had reduced the total period of illness and recovery to four weeks.

The infant had been given 2.1 mgm. intramuscular injections of "Aerosporin" every four hours for one day, and every three hours for four days. "Aerosporin" is being manufactured in London. It is an antibiotic and is made from the *Bacillus aerosporus*, which lives in soil and in the air. The most important feature of this new antibiotic is that it seems more effective than streptomycin in combating certain illnesses or their causes. For instance, it has been proved by experiments that "Aerosporin" gives mice complete protection against fatal doses of whooping cough organisms, whereas streptomycin fails entirely and sulfonamides are only partly effective. Much smaller quantities of "Aerosporin" are needed. In addition, the clinical dosage of pure "Aerosporin" has no apparent toxic effects. The bacteria attacked either develop no resistance to "Aerosporin" at all, or at least do so much less quickly than they do in the case of streptomycin.

As far as any judgment can be made from ten cases, the data published show that "Aerosporin" is a faultless, rapid, and effective cure for whooping cough if there is no secondary infection. For cases associated with other diseases, various remedies have to be combined. The administration of "Aerosporin" undoubtedly begins to cure whooping cough within the first forty-eight hours, however bad the attack. The quickness of the cure depends rather upon the promptness with which "Aerosporin" is given after coughing sets in than on the severity of the case. So a really effective remedy has at last been found.

## Maternal Mortality

The hazards of childbearing have been declining steadily in Canada for the past twenty-five years. As a consequence, the maternal death rate is now less than a quarter of what it was twenty-five years ago. The rate in 1947 — 15 deaths per 10,000 live births — is the lowest on record. The reduction is most marked in Alberta which averaged 66 deaths per 10,000 live births in 1926-30 compared to 9 in 1947. Quebec had the highest maternal mortality in 1947 — 22 per 10,000 live births, while the Prince Edward Island figure stands at 20 for the same year.

Many forces have contributed to this outstanding achievement. Women in increasing numbers have received the benefits of good prenatal care and of hospitalized delivery. At the same time, marked advances have been made in every phase of obstetrical practice. The sulfa drugs and penicillin have been the spearhead of the attack against puerperal infection, with the result that the death rate from this cause has been reduced at least two-thirds since 1935. Similarly, the more frequent use of blood transfusions has brought about an appreciable reduction in the number of deaths from hemorrhage and shock.

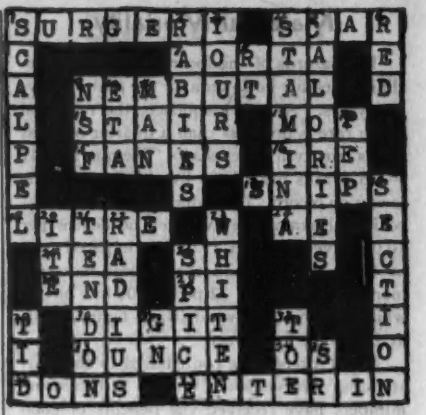
## Nursing Sisters' Association

The following members will serve as the executive of the *Toronto Unit* for the coming months:

President, Agnes Neill; vice-presidents, Jean Taylor, Dorothy Macham; recording and corresponding secretaries, Connie Bond and Laura Fair; treasurer, Edna Campbell. Committee conveners: Membership, Doris Kent; Blue Cross, Betty Galbraith. Miss Fair's address is 51 Kennedy Ave.

## Bottoms Up!

One of the advantages of fruit juices is the ease with which they can be prepared. A good method of doing this is to prepare a concentrated mixture of fruit juice and sugar which may be diluted to taste with water, soda-water, or ginger ale when required. Citrus fruits, such as oranges and lemons, may form the basis of this concentrate, but a truly Canadian touch may be given by adding rhubarb, strawberry or raspberry juice to the fruit drinks.




# News Notes

## ALBERTA

### CALGARY:

*General Hospital:*

The following officers were recently elected by the General Hospital Alumnae Association to serve during the coming months:

President, Mrs. H. B. Kirkpatrick; vice-presidents, Mmes H. J. Moore, A. C. Maberley, Miss V. Hall, Mrs. R. C. Straker; recording and corresponding secretaries, L. Shantz, I. Robertson; treasurer, Mrs. H. Thompson; extra executive, Mmes C. J. Stewart, A. S. Hammill, N. W. Griffiths. Committee conveners: Refreshment, Mrs. H. R. Honeywell; membership, Mrs. W. T. Brigden; visiting, Mrs. C. W. Boyd; social, Mrs. D. G. McInnes; carnival, Mrs. W. J. Treanor; banquets, Mrs. W. J. Tregillus; press, Mrs. H. Johnston.

The February meeting, in the form of a Valentine party, was held at the Blood Donor Clinic, when Mrs. T. L. O'Keefe outlined the work and achievements of the clinic and the nurses were taken on a tour of inspection.

The alumnae is sponsoring the Ice Cycles of 1949 to raise funds, part of which will be used for equipment for the hospital.

*Holy Cross Hospital:*

The Renfrew Club was the scene of the annual banquet held by the alumnae association in honor of the 1949 graduates. After an excellent dinner, the program opened with the singing of "O, Canada," with L. Thorne at the piano. Grace was said by M. Brown with F. Tennant proposing the toast to the King. The toast to the hospital and Sisters was proposed by Mrs. K. G. Calvert and replied to by V. Molesky. B. Kean gave the toast to the graduates, with N. Smith of the 1949 class replying. The president, M. Sparrow, addressed the graduating class

and Mrs. McQuade closed the program with the Nightingale Pledge. Approximately 140 attended this successful event, the conveners being Mmes R. Davidson, D. Shaw, and J. Robinson.

An alumnae project, which netted proceeds to go towards equipment for a premature nursery in the new wing of the hospital, was the raffling of a doll. This doll, complete with wardrobe made by alumnae members, was won by Mrs. J. Kichin of Luscar. The convener for this event was Mrs. R. McAdam.

The alumnae paper is printed three times a year — December 1, March 15, and June 15 — and is sent to each paid-up alumnae member. The editor this year is Frances Tennant, assisted by Joy Hermans.

EDMONTON:

Violet Chapman presided at a recent meeting of Edmonton District 7 when the revised By-Laws of the district were distributed. The guest speaker was Miss M. Dick, director, Welfare Bureau, whose interesting talk on welfare work was much enjoyed. A film was also shown entitled "Who is My Neighbor?"

*Royal Alexandra Hospital:*

At the annual meeting of the alumnae association it was again decided to offer a scholarship of $250 for post-graduate study to a member in good standing. The reports showed interest and progress during the year.

The following officers were elected: Honorary president, M. Fraser; president, Mrs. D. Ferrier; vice-presidents, G. Cawsey, B. Lea; recording and corresponding secretaries, E. Forestell, Mrs. R. Byar; treasurer, D. Watt. Conveners: Blue Book, Mrs. S. Boucher; benefit and loan, M. Griffith; scholarship, J. Stuart. Representative to press and *The Canadian Nurse*, V. Chapman.

## BRITISH COLUMBIA

ABBOTSFORD:

About seventy-five chapter members from Mission, Maple Ridge, New Westminster, South Fraser, Chilliwack, and Abbotsford sat down to an enjoyable hot supper which opened the annual district meeting of Fraser Valley. Mrs. Eric Dunning, the president, was in the chair when the annual reports were read. Each chapter also gave a report on their yearly activities. Miss Hamilton gave the report of the council meeting, reminding the members of the conference of the I.C.N. in Sweden in June. It was also noted that the provincial annual meeting is scheduled for April 22 and 23 in Vancouver. The treasurer's report showed a balance of $143. The New Westminster Chapter was asked to draw up by-laws for the District Association.

The guest speaker was Elizabeth Braund, provincial placement service director. She outlined the uses and requirements of the placement service, stressing the fact that it is only for nurses who have or have applied for their R.N. in British Columbia.

Mrs. Dunning will continue to serve as president, with Mrs. Ernest Robert as secretary, and Mrs. Tom Berry as treasurer.

CHILLIWACK:

Mrs. G. Roberts presided at the annual meeting of Chilliwack Chapter when twenty members were present. Letters of thanks were read from the Coqualeetza nurses. The Local Council report was given by Mrs. Barwell. Plans were made for sending another parcel to the chapter's "adopted" child in England. After the various annual reports were submitted discussion centred on the joining of the Recreation Centre. K. Crowley was appointed representative. The annual nurses' memorial service will be held at St. John's Church, Sardis, in May.

The following officers were elected: Honorary presidents, Mmes McKay, G. Wilson; president, Mrs. Roberts; vice-president, N. Kennedy; secretary, A. Bush; treasurer, Mrs. K. Arnold. Committee conveners: Press and publications, K. Crowley; visiting, Mrs. J. Barker; ways and means, M. Anderson; program, Mrs. F. Barwell; membership, F. Orton; overseas parcels, Mrs. D. Hayens. Representatives to: Local Council, Mmes Barwell, J. Barber, F. Storey, E. Taylor; *The Canadian Nurse*, C. Boland.

CRANBROOK:

With the thermometer registering 35° below, there was not a very large attendance at the Cranbrook Chapter annual meeting, held at St. Eugene Hospital. However, those present made up for the lack of numbers by their interest and enthusiasm. In the reports the following activities were noted:

Isobel Dunlop, chapter delegate, told the members about the R.N.A.B.C. annual convention held at Victoria; the graduating class were guests of honor at a reunion dinner; a rummage sale, in charge of D. Carter and the president, Mrs. C. Rendle, netted a substantial sum; a Christmas hamper was sent to a needy family and Christmas cheer extended to pensioned patients at the hospital.

The officers to serve for 1949 include: President, M. D. Gifford; secretary, D. Carter; treasurer, Dorothy Campbell.

VANCOUVER:

The following is a résumé of the annual report by Christine Charter, president, Vancouver Chapter:

"We broadened our professional interests by sending representatives to and hearing reports from the provincial annual meeting and the C.N.A. convention in Sackville; by having various speakers at our meetings who have brought up-to-date information on nursing procedures or on matters related to our profession; by electing representatives to local groups studying matters of civic, national, and international importance. By all of these means we have had opportunities of keeping in touch with current thinking and knowledge in matters of concern to us, both as nurses and citizens of the world.

"These are some of the things which have been done. 'From now on,' as Mr. Leonard Brockington put it in his New Year's message from Canada to the world, 'we are all

Forty-niners. What gold we discover this year is for each of us to determine.' Less than 5 per cent of the nurses in Vancouver attend chapter meetings. Many others must have much to contribute and eventually much to gain by taking a more active part in their profession. Unearthing such gold is not easy. Let each of us consider ourselves 'Forty-niners' and make a real attempt to bring more hidden material to the surface so that our chapter may not become static. We must recognize and press for priorities in needs, considering not only our rights as nurses, but such facts as the continued shortage of personnel, the need for nurses in many specialized fields, the need for improvements in educational methods, the need for intensifying our efforts to solve individual and community problems in the care of the sick. In a sense these are the responsibilities of the whole nursing profession, but in the final analysis they depend on each of us as thinking individuals working together."

The following officers will serve during the coming months:

President, C. Charter; recording and corresponding secretaries, Mrs. B. Love and W. Flack; treasurer, Miss Levenick. Committee conveners: Institutional nursing, H. Mussallem; private duty, C. Connon; public health, Miss Macdonell.

## MANITOBA

### BRANDON:

Carolyn Wedderburn presided at a recent meeting of the Association of Graduate Nurses when Mrs. R. Kent's group took charge. The guest of the evening, Mr. Roy Catley, was introduced by Mrs. Kent. The members enjoyed the films that he showed on wild bird life, winter sports, and Ukrainian holiday customs. The speaker was thanked by Mrs. M. McNee.

### ST. BONIFACE:

At the annual meeting and dinner held recently by the St. Boniface Hospital Alumnae Association, the following officers were elected:

Honorary president, Rev. Sr. Clermont; president, Mrs. J. A. Schimnowski; vice-presidents, T. Greville, Mrs. D. McDonald; recording and corresponding secretaries, H. Carlisle, Mrs. J. Hunter; treasurer, I. Skinner; archivist, Mrs. J. Schmidt. Committees: Social, P. Houston; membership, Mrs. H. Adams; scholarship, A. Laporte; visiting, Miss McDonald; nurses' directory, M. Manson; advisory, M. Wilson, Mmes M. Kerr, R. Willows. Representatives to: Press, Mrs. H. Mahaffy; *The Canadian Nurse*, J. Lylyk; Winnipeg Council of Women, Mrs. R. Letienne; M.A.R.N., V. Williams.

## NEW BRUNSWICK

### EDMUNDSTON:

A social evening, recently held by Edmundston Chapter, took the form of a chicken barbecue dinner when the members were pleased to have as their guest, Muriel Hunter, director of the provincial public health nursing service.

Mrs. M. V. Madore, the president, was

in the chair at a recent meeting. The chapter activities include: the furnishing of a room at Hotel-Dieu Hospital; a turkey dinner when a substantial sum was realized; comforts and gifts provided to ill members at Christmas; food parcel sent to an overseas nurse.

Dr. Armand Albert was the guest speaker at a later meeting when "Shock" was his subject. Mrs. Hilda Emmerson reported that another food parcel had been sent to an overseas nurse. A social entertainment, under the convenership of Mrs. Albina Titus, Jeannine Gendron, and Annette Sormany was an added attraction of the February meeting. About thirty members were present when four "Gypsies" arrived who, for a small token, were persuaded to look into the future.

The chapter annual meeting will be held in June. Edmundston has also been chosen as the scene for the provincial annual meeting September 27-29.

MONCTON:

At a recent meeting of Moncton Chapter, Phyllis Noble, the president, was in the chair. Letters of thanks were read from nurses in the Rest-Break Homes in England who had received parcels from the members. The guest speaker was Dr. Ian MacLellan, pathologist at Moncton Hospital. He gave an instructive lecture on "The Rh Factor," describing the reaction of the blood.

During the Christmas season, the senior students at the hospital were each given a gift by the chapter, and the Nurses Hospital Aid presented to the student body a record cabinet fitted with albums and sheet music for the piano.

SAINT JOHN:

Dr. G. E. Maddison, director of T.B. control for the N.B. Department of Health, addressed the Saint John Chapter at a recent meeting. The president, B. Seaman, was in the chair. The Public Health Section of the chapter saw two films at a regular supper meeting. The guests included K. Bell, instructor of nurses, General Hospital, and two student nurses — Misses Sanford and Cluet. G. Burns presided.

*General Hospital:*

B. Selfridge was re-elected president of the alumnae association at the annual meeting. A. Hanscombe was in the chair in the absence of the president. About thirty members were present and gratifying reports were received of the year's work. It was decided to make a special effort to approach all graduates in order to secure a larger active membership. A large quantity of food for overseas parcels was brought to the meeting. There will be sufficient to fill three boxes.

Additional members of the new executive include: Vice-presidents, K. Bell, S. Black; secretary and assistant, C. McLeod, Mrs. W. J. Bambury; treasurer and assistant, M. E. Handren, K. Lawson; program convener, L. Floyd; refreshment convener, Mrs. N. Neal.

The presentation of the R.R.C. award to Mary Elizabeth Reed by Lieut. Gov. Mac-

Laren was a feature of the 50th anniversary meeting of the Saint John branch of the V.O.N. A 1929 graduate, Miss Reed is V.O.N. National Office supervisor for New Brunswick, Quebec, and southern Ontario. She became the first matron of the military hospital in Fredericton and went overseas with No. 21 C.G.H. with the rank of captain (matron).

Honoring Lillian Wilson, night superintendent of nurses who is leaving to be married, the private duty nurses presented her with a tea set and an electric tea-kettle. Mrs. A. Corr made the presentation.

*St. Joseph's Hospital:*

The following officers were elected by the alumnae association at the annual meeting: President, M. Wallace; vice-president, M. Donovan; secretary, M. McNeil; treasurer, F. Wallace; executive, M. Carey, A. Ruland, Mmes J. R. Mullaby, J. McLaughlin; Blue Cross, K. McGillivray; visiting, C. Rogers, M. Riley; social, W. Ruland, M. Parsons; magazines, E. Ketchum, B. Martin.

## ONTARIO

### District 4

NIAGARA FALLS:

At the annual meeting of the Greater Niagara General Hospital Alumnae Association the following officers were elected: President, Mrs. J. A. Dick; vice-president, Mrs. E. Crawford; secretary, K. Pickard; treasurer, P. Connor.

### District 8

OTTAWA:

At a recent meeting of the Civic Hospital Alumnae Association, Dr. George Hooper gave an interesting address on "Cancer Research in Sweden." It was announced that $50 had been donated to the Association for the Blind. Evelyn Horsey, the president, was in the chair.

PEMBROKE:

At a recent meeting of the General Hospital Alumnae Association the following officers were elected: Honorary presidents, Rev. Srs. M. Camillus and St. Elizabeth; president, T. Sheahan; vice-presidents, G. Raddatz, L. Costello; secretary-treasurer, A. Schultz; corresponding secretary and *Bulletin* editor, B. Falconi; membership convener, Mrs. I. Kehoe; councillors, U. Lynn, Mmes T. Cully, H. Hein, G. Hennessy. The past president is Mrs. Kehoe.

### District 9

SAULT STE. MARIE:

Arranged by Rev. Sr. Teresa of the Sacred Heart and sponsored by District 9 from February 7-11, forty nurses registered for the series of lectures which were held at the General Hospital. So successful was this refresher course that it has been decided, with

the co-operation of the medical staff, to make it an annual event. The program included the following topics:

Dr. A. D. Roberts — diseases and abnormalities of the eye; Dr. C. H. Greig — modern treatment of burns; Dr. T. A. Breton — gynecology (round-table discussion); Mr. Brown, pharmacist — newer drugs; Dr. T. H. Black — obstetrics (demonstration of the conduct of a case); Dr. J. W. Gibson — cardio-vascular-nephritic disease; Dr. D. K. Newbigging — diseases common to the ear; Dr. W. E. Hutchinson — abdominal surgery; Mr. S. G. Trevor, medical laboratory technician — routine diagnostic tests. Mr. W. F. Buller, Dominion Oxygen Co. Ltd., representative, demonstrated oxygen therapy by means of motion pictures.

## District 10

### Port Arthur:

V. Weston presided at the annual meeting of District 10, while J. Smart acted as secretary-treasurer in the absence of Mrs. Fulton. The financial report was read by M. Spidell. It was revealed that a total of thirty-three food parcels had been sent to British nurses during the past year.

The following officers will serve during the coming year: Chairman, V. Weston; vice-chairman, Mrs. D. Easton; secretary-treasurer, Ina Lankinen, St. Joseph's Hospital, Port Arthur. Committees: Finance, D. Shaw; membership, M. Flanagan, M. Waters; program, O. Waterman. Sections: Hospital and school of nursing, Sr. Patricia, P. Richardson; public health, M. MacArthur, Mrs. V. Porter. Councillors, A. Hunter, Miss Wilson, J. Smart, O. Waterman, Sr. Felicitas. Representatives to: Press, G. Marino; *The Canadian Nurse*, J. Smart, L. Danberger. Mrs. W. Geddes chaired the Nominating Committee for 1949.

## QUEBEC

### Montreal:

*Children's Memorial Hospital:*

Joan Anderson has been appointed to the rotation staff. C. Reashor, after an extended leave of absence, has returned to the O.R. C. Moorhead and Greta Nichols, the latter to be married, have resigned.

*General Hospital:*

During January and February, various members of the nursing staff enjoyed the opportunity of hearing speakers in connection with the planned educational program of the McGill School for Graduate Nurses. Among the speakers were: Nettie Fidler, director, Metropolitan School of Nursing, Windsor, Ont., M. Faddis, associate professor, medical nursing, and R. Evans, associate professor, surgical nursing both from University of Western Reserve, Cleveland. Dr. Genevieve K. Bixler, educational consultant, who has made an outstanding contribution in the analysis of problems in the field of nursing education and service on a research basis, also took part in the program.

Dr. Guy H. Fisk, who is in charge of the physiotherapy department, was the guest speaker at a recent alumnae meeting when he gave a delightful talk on "Views of Flowers and Plant Life in Quebec."

Mabel K. Holt, former director of nursing, has returned to P.E.I. after spending some time in Montreal recently. Miss Birch entertained at the Western Division in her honor and also for Blanche Herman, who was in the city.

Agnes I. Tennant, director, social service department, who held the rank of Major in the R.C.A.M.C. Nursing Service, received the R.R.C. at the hands of His Excellency Viscount Alexander of Tunis at the recent Investiture in Montreal.

H. Mitchell and L. Fisher are on the O.R. staff, Central Division. P. Topp, M. Gage, F. Morrison, and P. Thurston are with the general duty staff. B. Royle, has resigned after valuable years of service as nurse in charge, Ward L, men's surgical. A. Christie resigned from the teaching department and is now an assistant to the night supervisor. I. J. Riley is another new addition to the night staff. M. Kneeland and B. Henchey have resigned from the O.R. to take a post-graduate course in O.R. technique at Johns Hopkins Hospital, Baltimore. M. Lewis has resigned as an assistant in the O.R. to take a position at Lamont, Alta.

Ruth Baker, an Australian nurse, who has been spending some months in England as a Nightingale International Foundation student, was at the Western Division for a month. She is travelling across Canada for periods of planned observation in various hospitals before returning to her homeland. J. Watling, B. Clarke, P. Hayman, M. C. Smith, J. M. Smith, V. Clark, R. Laughlin, and V. Monteith, all recent graduates, are doing general duty at the Western.

*Royal Victoria Hospital:*

Elizabeth Monk, M.A., B.C.L., was the guest speaker at a recent well-attended alumnae association meeting. Her subject was "Interesting Facts from Notarial Deeds in the Province of Quebec."

Joan (Patterson) MacCallum, former head nurse, Ward F, is doing part-time nursing on the wards in the main building as is Elizabeth (Armstrong) Van Vleit. Janet Cowie has been on the staff of the New York Neurological Institute for the past year. Beryl MacRae, nurse in charge of the outpost hospital, Fort George, Que., is spending her vacation in Montreal and at her home in Stellarton, N.S. Grace Martin, former assistant superintendent of nurses, and Mary Russell, assistant matron, *H.M.C.S. Donnacona*, Halifax, were recent visitors to the hospital.

## SASKATCHEWAN

HUMBOLDT:

The students of the training school of St. Elizabeth's Hospital were guests of the Humboldt Chapter and the hospital alumnae at a whist drive.

Officers serving for the chapter include: President, Sr. Marcella; secretary, Mrs. L. Stephenson; treasurer, Mrs. Carl Schenn.

MOOSE JAW:

Twenty-five members were present at a meeting of Moose Jaw Chapter when the guest speaker was Mr. A. Thomas, president, Sterling Motors, Pasadena, Calif. Mr. Thomas, a former resident of Moose Jaw, showed films of the annual Flower Parade in Pasadena and scenes of southern California.

*General Hospital:*

The following nurses are now on the staff: Assistant to nursing arts instructor, B. Anderson; operating-room, B. Pearce, B. Dunford; general duty, F. McPherson, D. Lawson, Mrs. D. Bennett; general duty — South Hill Annex, E. Borden, P. Clarke, M. Wilson.

*Providence Hospital:*

The following nurses are with the general duty staff: June Neden, P. Hearne, G. Hosie.

*Regional Health Centre:*

D. Code, senior nurse, is taking a month's course in mental hygiene at the Provincial Hospital, Weyburn. G. Harkness has re-

turned from taking a similar course. E. Mathews and P. Wright are now on the staff.

REGINA:

A recent interesting meeting was conducted by the Institutional Committee of Regina Chapter. Included among the speakers were the following: Grace Spice, instructor of science, G.N.H., and Alice Lecour, clinical instructor, G.N.H. — applying classroom teaching to the actual situations in hospital; Ethel James, educational director, R.G.H. — field of curriculum planning, staff education programs, responsibilities of director of education, etc.; Wilma Matheson — influence of general staff nurse on student; E. L. Hennigar — head nurseship; Margaret Kovac, O.R. supervisor, R.G.H.— service patients receive through teamwork and co-operation; K. Magee, head nurse, cancer clinic, G.N.H.— activities of clinic, emphasizing the fact that 25 per cent of beds in hospital are occupied by clinic patients.

*Grey Nuns' Hospital:*

Fifty-nine preliminary students received their caps recently, while a new class of thirty was admitted in February.

A "no-hostess" tea was held in Vancouver when a number of Grey Nuns' graduates met. Classes from 1909 to 1945 were represented.

New staff members include: Sr. Drouin, ward supervisor; N. Mullen, 1st floor; B. Hailstone and Alberta (Richardson) Haffley, 2nd floor. Members of the 1949 class, who have taken positions on the staff, include: H. Abello, dressing room; M. Holliday, O.R.; L. Bonneville, 1st floor; L. Tomlenovich, men's surgical. K. Henderson is taking a course in deep x-ray therapy.

SASKATOON:

St. Paul's nurses' residence was the scene of a Valentine Tea, sponsored by Saskatoon Chapter. Receiving the guests were L. Costello, M. Schwanbeck, and M. Jarvis. The tea table was presided over by M. Luten, M. McKenzie, M. R. Chisholm, L. Rechenmacher, and Mmes Porteous and Galt. Miss Chapman, of the Sanatorium, won the door prize.

An informal party was held recently in honor of M. E. Grant who has retired after twenty-five years' service with the City Health Department. A corsage and leather purse were presented to her by the chapter president, Miss Costello. (See Nursing Profiles, Feb. issue.)

*City Hospital:*

The School of Nursing Alumnae Association held their annual membership tea when Ethel Grant and F. McLean presided at the tea table. Receiving the guests were Misses Chisholm, B. Robinson, and C. Cowan. D. Bell took charge of the register. Mrs. H. L. Wilson and L. Knighton were the conveners for this successful event.

Thirty-five members of the 1951 B class of the school of nursing recently received their caps at an impressive candle-lighting ceremony. It was a special occasion for two alumnae members whose daughters received their caps. The newly-capped students were welcomed to the school by Mrs. Porteous, and H. Baxter, president, Student Nurses' Association, received them into that group.

D. Munro has joined the staff.

*St. Paul's Hospital:*

On February 3, sixteen students finished their three-year course. The same day twenty-three "probies" were admitted. The capping ceremony of thirty-five Freshmen B took place recently, followed by a welcome party given in honor of Freshmen A and the new class. V. M. Hendren has left Saskatchewan to take a course with T.C.A. Mr. and Mrs. W. Murphy have donated a combination radio-gramophone to the children's ward.

*Saskatoon Sanatorium*:

New members on the staff include: D. Blondeau, T. Fitzgerald, A. Dawson, and M. Baraniecki.

SWIFT CURRENT:

Mrs. W. Bue has joined the Swift Current Chapter and is planning to serve on the hospital staff. D. Armstrong, who has taken a post-graduate course in surgery at the Michael Reese Hospital, Chicago, has joined the hospital staff as O.R. scrub nurse. L. Wheeler, D. Sherwood, A. Peterson, and L. Thorarinson have resigned, planning to live in Calgary.

YORKTON:

Following a regular meeting of Yorkton Chapter, an interesting talk was given by Dr. H. A. L. Portnuff on his trip to California and New Mexico. The chapter entertained members of the Business and Professional Women's Club at a social evening. C. Colville is taking a four-month course in O.R. technique at the Vancouver General Hospital.

# Positions Vacant

**• CANADIAN RED CROSS SOCIETY •**

invites applications for Administrative and Staff positions in Hospital and Public Health Nursing Services for various parts of Canada.

The majority of opportunities are in Outpost Services in British Columbia, Saskatchewan, Manitoba, Ontario, Quebec, New Brunswick, and Nova Scotia. Commensurate salaries for experience and qualifications. Transportation arrangements under certain circumstances.

*For further particulars apply:*

**National Director, Nursing Services, Canadian Red Cross Society, 95 Wellesley St., Toronto 5, Ont.**

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**Supt. of Nurses** for the General Hospital, Port Arthur, Ont. To be in complete charge of Nursing Service, including Ward Aides & Orderlies, & to relieve Supt. 250 beds. Training School of 42 students; an Instructor & Clinical Supervisor. Salary: $250 with full maintenance for nurse with adequate experience. Apply, stating qualifications & references, Miss A. B. Hunter, Supt.

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**Supt. of Nurses** for Leamington District Memorial Hospital, now under construction. Will require Supt. in addition to Business Manager. Applications for position of Supt. should be submitted to M. S. Dixon, Chairman, Personnel Committee, 42 Marlboro St. W., Leamington, Ont.

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**Asst. Supt.** for 68-bed General Hospital. Commencing salary: $135 per mo. plus full maintenance. Apply, giving full particulars, Supt., Public Hospital, Smiths Falls, Ont.

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**Matron & General Duty Nurses** for modern 20-bed hospital. Salary: $170 & $135 per mo. with maintenance. 8-hr. day, 6-day wk. Usual holidays. Apply Miss A. Scott, Mayerthorpe, Alta.

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**Graduates** who have had post-graduate work in Teaching & Supervision to act as **Clinical & Junior Instructors** in large School of Nursing. Apply c/o Box 5, The Canadian Nurse, Ste. 522, 1538 Sherbrooke St. W., Montreal 25, Que.

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**Registered Nurse for Night Supervisor.** Also **Day Supervisor.** Apply Supt., General Hospital, Guelph, Ont.

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**Graduate Nurse** for Mackay Memorial Hospital, Formosa, urgently needed by Presbyterian Women's Missionary Society. A deep interest in Christian advance, along with professional experience, is required. For further information apply Mrs. A. R. McMurrich, Candidates Sec., Rm. 800, 100 Adelaide St. W., Toronto 1, Ont.

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**Public Health Nurses** for generalized Public Health work in County Health Unit. Halfway between Ottawa & Montreal. Salary: $1,900 to start. Cars provided. Must be bilingual (French & English). Apply, stating age, experience, etc., Director, Prescott & Russell Health Unit, 33 Main St. W., Hawkesbury, Ont.

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**Public Health Nurses** for Northumberland-Durham Health Unit. Salary range: $1,800-$2,500 according to experience. Car provided or car allowance. Direct inquiries to Dr. C. W. MacCharles, M.O.H., Cobourg, Ont.

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**General Duty Nurses.** Salary: $130 for first 6 mos. & $135 after 6 mos. service plus maintenance. 8-hr. day, 6-day wk. 2 wks. holidays after 1 yr. service plus statutory holidays. Apply Supt. of Nurses, Municipal Hospital, Brooks, Alta.

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**General Duty Staff Nurse** for beautiful new 29-bed Union Hospital, Foam Lake, Sask. Newly furnished residence with connecting tunnel. 8-hr. day, 6-day wk. 4 wks. annual holiday. Salary: $140 per mo. plus full maintenance. For further particulars or employee contract forms apply Director of Nurses.

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**Nursing Arts Instructor** for 300-bed hospital. Gross salary: $190. Duties to commence Aug. 1. 8-hr. day, 6-day wk. 1 mo. vacation annually. Apply Supt. of Nurses, McKellar Hospital, Fort William, Ont.

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**Educational Director & Science Instructor** for 250-bed hospital with 135 students. 5½-day wk. 1 mo. vacation with pay after 1 yr. service. Position open for Fall. **Supervisor for new Surgical Wing.** 3 floors, 16 beds on each. Head Nurse covering each floor. Apply, stating qualifications, experience, salary expected, Grace Hospital, Winnipeg, Man.

**Graduate Nurses (3) for General Duty** for 20-bed hospital. Salary: $125 per mo. with full maintenance. Apply Miss G. Dixon, Matron, Municipal Hospital, Provost, Alta.

**Director of Nursing Education** to plan Educational Program & assist in teaching Science or Nursing Arts subjects. **Science Instructor** to teach the Basic Sciences & any preferred specialty. Apply, stating qualifications, Director of Nursing, General Hospital, Saint John, N.B.

**Nursing Arts Instructor & Science Instructor** for Fall term. 138-bed hospital. 60 student nurses. Apply, stating qualifications, to Supt. of Nurses, General Hospital, Yorkton, Sask.

**Operating-Room Supervisor & Nursing Arts Instructor.** Immediate opening. Good location. State Capitol with many civic advantages. Salary open. Apply Director of Nurses, Evangelical Hospital, 6th & Thayer, Bismarck, North Dakota.

**Ward, Evening & Night Supervisors** for 160-bed hospital in Saskatchewan. Straight 8-hr. day. Salary range: $170-$225 per mo., depending on qualifications. Apply c/o Box 4, The Canadian Nurse, Ste. 522, 1538 Sherbrooke St. W., Montreal 25, Que.

**X-Ray Technician** (preferably Graduate Nurse) who could assume part-time nursing duties. Apply Supt., Carleton County, L. P. Fisher Memorial Hospital, Woodstock, N.B.

**Graduate Dietitian** at Ontario Hospitals in Brockville, Kingston, Whitby, Woodstock. Initial salary: $2,140 per annum, plus $180 Cost of Living Bonus, less perquisites ($26.50 for room, board, laundry). Annual increment, accumulative sick leave, superannuation, 3 wks. vacation, statutory holidays & special holidays with pay. 8-hr. day, 6-day wk. Apply Supt. at above hospitals.

**Registered Nurses for General Staff** at Ontario Hospitals in Brockville, Hamilton, Kingston, London, New Toronto, Orillia, St. Thomas, Toronto, Whitby, Woodstock & Toronto Psychiatric Hospital. Initial salary: $1,840 per annum, plus $180 Cost of Living Bonus, less perquisites ($26.50 for room, board, laundry). Annual increment, accumulative sick leave, superannuation, 3 wks. vacation, statutory holidays & special holidays with pay. 8-hr. day, 6-day wk. Apply Supt. of Nurses at above hospitals.

**Vancouver General Hospital** requires: **Asst. Night Supervisor.** Salary: $227 gross, including current Cost of Living Bonus. **General Staff Nurses** for *vacation relief*. Salary: $172 gross, including current Cost of Living Bonus. Extra premium for evening or night duty. Registration in British Columbia required. For further information apply Director of Nursing, General Hospital, Vancouver, B.C.

**General Staff Nurses,** 44-hr. wk. Starting gross salary: $155. Registration in British Columbia essential. Apply Supt. of Nurses, Royal Columbian Hospital, New Westminster, B.C.

**Graduate Nurses for General Duty** for new 60-bed B.C. coast hospital, newly equipped, to open March 1. Located on coastal Inland Passage 150 miles north of Vancouver. Salary: $150, less $25 board, room & laundry. 1 mo. annual vacation with pay. 8-hr. day, 6-day wk. Arrangements can be made to advance transportation via TCA on the undertaking to remain on staff for a minimum of 1 yr. Transportation to be reimbursed to hospital by monthly payments. Apply, giving age, qualifications, training school, etc., Administrator, St. George's Hospital, Alert Bay, B.C.

**General Duty Nurses.** 8-hr. broken day. 48-hr. wk. Gross salary: $163.40 monthly. All salaries have scheduled rate of increase. Cumulative sick leave. Pension plan in force. Blue Cross plan, 3 wks. holiday after 1 yr. service. Apply Supt. of Nurses, Muskoka Hospital for Tuberculosis, Gravenhurst, Ont.

**General Duty Nurses** for 350-bed Tuberculosis Hospital. Blue Cross hospitalization plan. For further information apply Miss C. L. Bartsch, Supt. of Nurses, Royal Edward Laurentian Hospital, Ste. Agathe des Monts, Que.

**Registered Nurses for General Duty.** Salary: $120 per mo. plus meals & laundry. Apply Rotary Hopewell Hospital, Leamington, Ont.

**Instructor & Supervisor for Operating-Room** in 285-bed hospital. Minimum salary: $250 per mo., plus room, meals, laundry. Apply Director of Nursing, Good Samaritan Hospital, S. Limestone St., Lexington, Kentucky.

**Asst. Night Supervisor** for 275-bed hospital. Some experience in Obstetrics necessary but no Operating-Room responsibility to be taken. Minimum salary: $150 with full maintenance. Further consideration given applicants with experience. For further information write or wire collect Supt. of Nurses, General Hospital, Port Arthur, Ont.

**Nurses (2)** for 25-bed United Church Mission Hospital on British Columbia coast. Salary begins at $120 per mo. & maintenance. 5 wks. annual holiday. Travelling allowance. Apply General Hospital, Bella Coola, B.C.

**Nursing Arts Instructor** for Brandon Mental Hospital Affiliate School of Nursing. Excellent classroom facilities. Classes Jan. & Aug. Duties commence Aug. 1. Opportunity for attending post-graduate lectures in Psychiatric Nursing, Psychiatry, Neurology, Mental Hygiene or Psychology. For information regarding salary, vacation, pension plan, hours of duty, etc., apply Supt. of Nurses, Brandon Hospital for Mental Diseases, Box 420, Brandon, Man.

**Instructor of Nurses.** For full particulars apply Miss Rhoda F. MacDonald, Supt., Payzant Memorial Hospital, Windsor, N.S.

**Night Supervisor & General Duty Nurses** for General Hospital, Parry Sound, Ont. Apply, giving full particulars in first letter, to Supt. of Nurses.

**Registered Nurses** for 125-bed General Hospital in Interior of British Columbia. Salary: $150 gross; $30 deducted for room, board, laundry. 3 wks. vacation with pay after 1 yr. service. Accumulative sick leave—12 days a yr. 7 statutory holidays. Apply, stating training, experience, post-graduate courses, Supt., Trail-Tadanac Hospital, Trail, B.C.

**Operating-Room Supervisor** immediately. Salary: $170. 44-hr. wk. Must be eligible for B.C. registration. Apply Supt. of Nurses, Children's Hospital, 250 West 59th Ave., Vancouver, B.C.

## Human Engineering

Men live on this planet, all over it. Where they live and their types depend on the soil and the weather. But they differ very little from one another—slight differences in skin color, head shape, and other surface indications. Fundamentally, they are all the same. Yet how slow we have been in making the best use of ourselves.

In suggesting that we apply better engineering methods to ourselves and our society it is not recommended that we beat ourselves to a pulp in order to produce a new man better able to take care of himself. In some respects it may be argued that we have been doing a great deal of that in recent years without achieving very much. Neither does it seem wise to boil men down into an oily liquid . . .

But we can get rid of fallacious ideas and, as good engineering allows more efficient use of materials and provides for a better product, reduce the waste effort of men and women in our society. No longer need we be hampered with the fallacy that human nature can't be changed for we know that man does change both his approach and his attitude with his change of knowledge.

We know a little more about men than we did formerly. We can make use of that knowledge to allow men to live more harmoniously and, when we do, we shall have engineered for greater efficiency in human efforts, removing some of the waste activity that now takes up so much energy. Racial and religious antagonisms are some of that waste effort.

We need to know more about men. But with what we already know we can engineer a better society free from wasteful antagonisms. There can be no doubt that the cost of this work will be repaid a thousandfold. Crying humanity all over the world is asking for just this leadership.

## Annual Meetings

**Alberta** — Calgary, *April 29-30.*
**British Columbia**—Vancouver, *April 22-23.*
**Ontario** — Ottawa, *April 18, 19, 20.*
**Quebec** — Montreal, *May 30-31.*
**Saskatchewan** — Regina, *May 26-27.*

**REGISTRATION OF NURSES**

**Province of Ontario**

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**EXAMINATION ANNOUNCEMENT**

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An examination for the Registration of Nurses in the Province of Ontario will be held on **May 18, 19 and 20.**

Application forms, information regarding subjects of examination and general information relating thereto, may be had upon written application to:

**The Director,**
**Division of Nurses Registration**
**Parliament Buildings, Toronto 2**

# Official Directory

## CANADIAN NURSES' ASSOCIATION

### 1411 Crescent St., Montreal 25, Que.

**President**..... Miss Ethel Cryderman, V.O.N., 251 Sherbourne St., Toronto 2, Ont.

**Past President**..... Miss Rae Chittick, 815-18th Ave. W., Calgary, Alta.

**First Vice-President**..... Miss Evelyn Mallory, 1086 West 10th Ave., Vancouver, B.C.

**Second Vice-President**.... Miss Marion Myers, Tuberculosis Hospital, East Saint John, N.B.

**Third Vice-President**..... Miss Lyle Creelman, c/o Canadian Public Health Ass'n, 150 College St., Toronto 2B, Ont.

**General Secretary-Treasurer**... Miss Gertrude M. Hall, Suite 401, 1411 Crescent St., Montreal 25, Que.

#### OTHER MEMBERS OF EXECUTIVE COMMITTEE

***Presidents of Provincial Associations—***

**Alberta**..... Miss Blanche Emerson, 23 Rene LeMarchand Mns., Edmonton.

**British Columbia**..... Miss Evelyn Mallory, 1086 West 10th Ave., Vancouver.

**Manitoba**..... Miss Irene M. Barton, Veterans' Home, Winnipeg.

**New Brunswick**..... Miss Hilda M.Bartach, Tuberculosis Hospital, Moncton.

**Nova Scotia**..... Miss Maisie Miller, Victoria General Hospital, Halifax.

**Ontario**..... Miss Nettie D. Fidler, 849 Kildare Rd., Windsor.

**Prince Edward Island**..... Mrs. Lois MacDonald, P.E.I. Hospital, Charlottetown.

**Quebec**..... Rév. Soeur Valérie de la Sagesse, Hôpital Ste-Justine, Montréal 10.

**Saskatchewan**..... Miss Ethel James, General Hospital, Regina.

(In addition to the presidents, one other member of the administrative body of each provincial association or its executive secretary is a member of the Executive Committee.)

***Religious Sisters (Regional Representation)—***

**Maritimes**..... Rev. Sister Mary Beatrice, St. Joseph's Hospital, Glace Bay, N.S.

**Quebec**..... Rev. Sr. Denise Lefebvre, Institut Marguerite d'Youville, 1185 St. Matthew St., Montreal 25.

**Ontario**..... Rev. Sister St. Albert, St. Michael's Hospital, Toronto 2.

**Prairies**..... Rev. Sister Mary Irene, Holy Family Hospital, 15th St. W., Prince Albert, Sask.

**British Columbia**..... Rev. Sister Mary Claire, St. Joseph's Hospital, Victoria.

***Chairmen of National Committees—***

**Constitution, By-laws and Legislation**..... Miss Nettie D. Fidler, 849 Kildare Rd., Windsor, Ont.

**Educational Policy**..... Miss Agnes Macleod, Treatment Branch, Dept. of Veterans Affairs, Ottawa, Ont.

**Institutional Nursing**..... Miss Elinor Palliser, General Hospital, Vancouver, B.C.

**Labor Relations**..... Miss Ina Broadfoot, Canadian Red Cross, 31 Kennedy St., Winnipeg, Man.

**Private Duty Nursing**..... Miss Barbara Key, 123 Bold St., Apt. 56, Hamilton, Ont.

**Public Health Nursing**.... Miss Trenna Hunter, Metropolitan Health Committee, City Hall, Vancouver, B.C.

#### EXECUTIVE OFFICERS

**Alberta Ass'n of Registered Nurses**, Reynolds Bldg., 10036-102nd St., Edmonton.

**Registered Nurses' Ass'n of British Columbia**, Miss Alice L. Wright, 1101 Vancouver Block, Vancouver.

**Manitoba Ass'n of Registered Nurses**, Miss Lillian Pettigrew, 214 Balmoral St., Winnipeg.

**New Brunswick Ass'n of Registered Nurses**, Miss Alma F. Law, 29 Wellington Row, Saint John.

**Registered Nurses' Ass'n of Nova Scotia**, Miss Nancy Watson, 301 Barrington St., Halifax.

**Registered Nurses Ass'n of Ontario**, Miss Florence H. Walker, Rm. 715, 86 Bloor St. W., Toronto 5.

**Prince Edward Island Registered Nurses' Ass'n**, Miss Verna Darrach, 62 Prince St., Charlottetown.

**Association of Nurses of the Province of Quebec**, Miss Margaret M. Street, 506 Medical Arts Bldg., Montreal 25.

**Saskatchewan Registered Nurses' Ass'n**, Miss K. W. Ellis, 104 Saskatchewan Hall, University of Saskatchewan, Saskatoon.

#### ASSOCIATION OFFICERS

**Canadian Nurses' Association:** 1411 Crescent St., Montreal 25, Que. *General Secretary-Treasurer*, Miss Gertrude M. Hall.

**International Council of Nurses:** 19 Queen's Gate, London S.W. 7, England. *Executive Secretary*, Miss Daisy C. Bridges.